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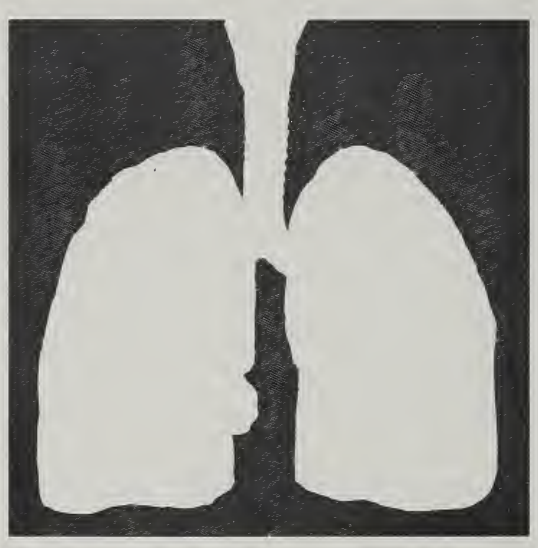

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Front Cover

A slate colored Junco (snowbird) takes a break on the branch of a pine tree. Photo courtesy of *Scott Durham* of Pineville.

Why health care reform must still be addressed: A medical student's inside look at Washington

JOHN DAVID Y. CABRAL, MSII
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Editor's Note: John Cabral is a second-year medical student at the Boston University School of Medicine and School of Public Health, who is from Princeton, W.Va. This past summer he served as a congressional intern in the office of Senator Jay Rockefeller in Washington, D.C.

When I was accepted as an congressional intern in the office of Senator Jay Rockefeller this past summer, I vowed to myself that I was going to solve the health care crisis for the nation and West Virginia during my five-week term - - quite a daunting task at age 23.

Like President Clinton, I was very naive to think that I could enact major changes in our health care system in a short period of time, but I'm very glad I was involved in some small way in the initial effort. My experiences in Washington, D.C., opened my eyes in many ways, especially to the fact that there are some very real problems with our health care system that will not go away unless we work toward some solutions.

Arriving in Washington, D.C., last July, I thought politics was going to be easy since I had already taken many public health classes such as health care finance, accounting, economics, and negotiations and policy. My confidence had also been very foolishly boosted by playing a computer simulation game called Sim Health, in which I had written my own plan for health care reform. I had named my proposal the "Princeton Bill" in honor of my hometown, and the computer told me that with all the parameters I had included, I was going to be able to keep the federal budget within inflation, anger insurance companies and lawyers, increase access to care, and reduce paperwork, as well as be re-elected in four years with a public approval rating of 81%!

It wasn't long though before my ego was shattered and I was given my first big assignment - - retyping and organizing the Roladex of Senator Rockefeller's Legislative Assistant Mary Ella Payne! I said to myself "This must be a joke! I studied a year and a half for this congressional experience, and all I get to do is retype 500 roladex cards." I was so mad that I mumbled under my breath during the first 100 Roladex cards, but by the time I had reached the 450th card, I began to realize the importance of this exercise. There were a huge number of players in the health care reform game ranging from the First Lady (I took her old card with her personal number and put it in my wallet) to the Parent Teachers Association. Each one of them had their own opinion on health care as well.

By the second week, my main role in Senator Rockefeller's office was to attend both Senate/House briefings and committee meetings on health care reform, and then report back to Mary Ella. I was able to attend meetings on such issues as video electronic imaging used in VA hospitals, ERISA laws, budgetary considerations, information accessing, etc. That same week, I finally met Senator Rockefeller, who promptly tapped me on the shoulder and said, "Go get'em, tiger!" His comment made me feel like now I was definitely headed for greatness.

During the heat of the health care debate in Congress last summer, Senator Jay Rockefeller and medical student John Cabral took time out for a photograph. ***(Photo by Noel Clay.)***

At my internship, I felt on top of the world on Fridays and underneath it on Mondays, Tuesdays, Wednesdays, and Thursdays. When you sit at any Senate hearing, briefing or committee meeting, they talk in really big numbers - - 534 billion for long term care, x billion for this, x billion for that. More and more I was beginning to realize that the money for health care is someday going to run out.

Throughout my internship, I saw lobbyists from all walks of life - - from insurance companies, big businesses, small businesses, government agencies, and even doctors. Of all the lobbyists, the ones that I remember most are the ones that weren't professionals - - the general public. Senator Rockefeller receives 6,000-7,000 letters each week and hundreds of phone calls. The letters that involve everyday

people and children are the ones that made the biggest impact on me. But how can you relate these feelings into an economic market? It was really rough making decisions for Senator Rockefeller.

For example, one of the most difficult questions I had to reflect on when dealing with the various health care proposals, was whether or not community ratings or age ratings are the most fair for the public. Community ratings base insurance premiums on geographic areas, and this type of system is now working very well in places like Rochester, N.Y., and Hawaii. Some people, though, believe it is fairer to base insurance premiums on the ages of the individuals in specific areas because they think the elderly utilize health care more and are better off financially due to pensions. I came to the conclusion, though, that both the young and the old must work together because at one time or another we all must utilize health care.

One of the great experiences about being involved with the health care debate last session was meeting other people from around the nation who were also concerned about reform issues. If I learned anything from my internship, I learned that no health care system is perfect. When you speak to people from Hawaii or Maryland, where highly regarded health systems are in place, they say they are having problems just like the other states.

During my five weeks on Capitol Hill, I also had a great deal of contact with the Veterans Committee, which provided me with another eye-opening experience in terms of thinking about what would be best for our country. When I had written my Princeton Bill for the simulated computer game, I had proposed to drastically reduce the size of VA hospitals because I thought it was a measure that would reduce costs and increase patient satisfaction. After one week of working with the Veterans' Committee, I realized I was wrong. What are we supposed to do with the 28 million veterans that use VA medical services? This is one of the many obstacles that I came to realize in policymaking - - everyone cannot get everything.

What can I say about Senator Rockefeller? Whether you like him or not, he is dedicated to the health care of our country and West Virginia, and I am not just saying this to gain favors from him. When you see him talking to other legislative assistants or other senators in any hearing or meeting regarding health care, he seems to have a genuine understanding of almost all aspects of our present system. He does not rely on cue cards and buzzwords that the public likes to hear, but his knowledge comes from actually studying many of the financial and economic factors involved in delivering health care.

I found it very upsetting to realize that while Senator Rockefeller is very knowledgeable about health care coverage, there are congressmen and women who know nothing at all except re-election key words. National health care, like all personal and political issues, cannot be created without taking into account the personal values of those creating it. Although Rockefeller is an excellent senator in terms of health care, I do not agree with all of his policy decisions, like work force issues and physician liability; however, I do respect him and his effort.

Of course, one of the other harsh realities about policymaking I learned was that everything is based on money. Three of the most powerful voices in the debate over health care last session were the CBO (Congressional Budget Office), the GAO (General Accounting Office), and the OMB (Office of Management and Budget). Budget neutrality is just as important as patient satisfaction on Capitol Hill. In the hospital, it is the other way around.

Did I understand everything that was presented to me? No, but I don't think that anyone on Capitol Hill could be called a total health care expert. At times, I felt that I was an expert on some of the issues, while at other times, I was in hearings where I found myself doodling aimlessly because I was so confused about what exactly was going on around me.

I had hoped the debate would not come down to a conflict of personalities, partisanship, and strategy on Capitol Hill, but it did. Some of the meetings that I attended concerned intense political strategy, and actions like striking, default options, amendment timing, filibusters, and House agreements began making me ill. Strategy and personalities should not take the forefront to the plethora of data and studies.

As the debate over health care continued, it became more and more of a chess game. Each move had a countermove with other players. Regular chess is easy because there are only two players; but the Congressional chess game that was being waged over health care was mindboggling because there were 100 senators, 435 representatives, and 260 million viewers playing for 14% of the GDP. This was no game, it was a battle, and I don't believe anyone won! The legislative process is a complex procedure with alternatives to alternatives, committees to committees, drafts on drafts, and amendments to amendments. Sometimes, I wish there was a better way to make decisions on Capitol Hill, but I cannot think of any. Dictatorships are great only when everyone agrees.

There was enough data presented to show that universal coverage will help most U.S. citizens, and after studying the situation thoroughly, I believe that employer mandates are our best way to pay for it. States like Hawaii and New York have shown this fact. Hawaii, with universal coverage, has 30% lower premiums than the mainland, while overall prices are higher. New York, which doesn't have universal coverage but does have major insurance reforms such as guarantee issue renewal of insurance and uniform community ratings, has seen an 18% increase in premiums due to adverse selection where younger, healthier people will opt out of the insurance plan.

On the other hand, the Committee for a Financially Responsible Budget presented three studies to show that if employer mandates were used to pay for universal coverage, there would be a substantial reduction in jobs, especially lower wage jobs. Society must decide on the opportunity costs of either providing more jobs or securing the health status of most Americans. What are we to do? There is no magic bullet that will solve health care.

As time came close to the end of my internship, the debate just got hotter. People in Senator Mitchell's office made sure that no information leaked out to the press and the lobbyists. Strategies and maneuvering were the main topics when the final bill came out because everyone from Senator Mitchell's and Senator Rockefeller's offices were busy making sure that every component and decision was structured around the CBO since everything had to be deficit neutral.

At the end of my five weeks in Washington, I wondered if my Princeton Bill would have really worked. Unlike the computer simulation, people get hurt on Capitol Hill, and I really wasn't ready to make any more decisions. Was it worth it to Senator Rockefeller and the taxpayers of the nation to send me here? In the short run, probably not, but in the long run, it was a great experience for me, and hopefully it will make me more involved in West Virginia's health care policies in the future.

As a future physician, I do not believe on setting limits on medical students or residents. As an economist and politician, it only seems right to set limits on physician supply and demand. More decisions without any answers.

When I drove home to Princeton after my internship, I saw the town in a very different light because I realized that many of the businesses located there are owned by corporations who have written Senator Rockefeller letters opposing employer mandates. It really made me think about how health care reform will touch the lives of each and every individual. I also felt a certain sense of responsibility to the citizens of Princeton, as well as the residents of the state because I had been an intern for five weeks and the health care bill had not been passed.

Now, with the new Congress in session, it is very obvious that health care will not be a top priority, which I think is very unfortunate. During my internship, I heard a staff member of the CBO make a speech in which he stated that by 1998, Medicare fund will be totally diminished. It is obvious that if we keep letting health care costs skyrocket, we're just feeding the system and not addressing the problem. I believe that we are playing on a time line and the longer we wait to address health care reform, the more we will end up hurting the country.

In order to find out what the agenda would be for health care this session, I recently wrote the president through the E-Mail (President@WhiteHouse.gov). I asked about his future plans for health care reform and if I could have a picture of Soxs his cat. All I received was a form letter two days later with no picture, in which he said that he is excited to work with the new Congress on these issues. What a letdown!

Even though I am not at the forefront of health care reform, we cannot just forget about the problems of the last Congress. Health reform is not just a Democratic or Republican problem, and it is not just a problem for a certain section of society or certain profession. It is an everyday problem for everyone. I was naive and selfish in thinking that I could solve the problem in five weeks. The Clinton administration was also overzealous that they could drive health care reform without seeking out the advice of key Republicans.

This internship has brought me to a side of medicine that I have never been a part of - - politics. I hope that this experience will help me become a better doctor, but I feel that spending time in Washington has taken some of my innocence about the world away. Is the debate just about money? I hope not. So, when I start to see patients, do I look at them as a part of an insurance pool, a managed care contract, or reimbursement source with money and costs in the back of my mind? No. I think I will just ask them their name, ask them what brings them to my office or the hospital, and take it from there.

Before I left Washington, I prayed that health care would be universal, health costs would decrease, doctor-patient trust would be restored, health care innovations would continue, understanding the new health system would be easy for the public, mortality rates from preventive diseases would decrease, and America could concentrate on more pressing summer issues - - like baseball before the new year came. The new year has come and nothing has changed. My initial thoughts were to give up and blame it on politics as usual. However, that is too easy to do.

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A case study of abdominal angina secondary to celiac compression syndrome

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Abstract

Celiac compression syndrome occurs when the median arcuate ligament of the diaphragm and/or periarterial neural tissue causes extrinsic compression of the celiac axis. In rare cases, this sydrome can cause upper abdominal angina. The classic triad of celiac compression syndrome consists of abdominal pain, an epigastric bruit, and angiographic evidence of celiac compression. Operative therapy consists of thorough exploration, transection of the median arcuate ligament, and either celiac dilatation or a bypass. This article describes a case of celiac compression syndrome which was treated successfully by transection of the median arcuate ligament and aortosplenic bypass.

Figure 1. Arteriogram of an aorta free of atherosclerosis.

Introduction

Celiac compression syndrome occurs from impingement upon the celiac axis by the median arcuate ligament of the diaphragm, and it is an unusual cause of upper abdominal angina (1-7). Unlike the usual causes of abdominal angina, celiac compression syndrome usually occurs in the face of an otherwise normal aorta free of atherosclerotic disease.

Since celiac compression syndrome is rare and can mimic many intra-abdominal processes including malignancy, it is often misdiagnosed. For surgical intervention to be beneficial, proper patient selection is crucial. If surgery is an option it must consist of thorough exploration, transection of the median arcuate ligament, and either celiac dilatation or a bypass.

Figure 2. Arteriogram showing severe stenosis of the celiac axis.

Case report

A 57-year-old, white female was referred to the Vascular Laboratory at the Charleston Area Medical Center to obtain a second opinion regarding a two-year history of chronic right upper quadrant and epigastric pain, bloating, nausea and vomiting. She had already undergone an ultrasound of the gallbladder, HIDA scan and multiple upper endoscopies, including an endoscopic retrograde cholangiopancreatography (ERCP), computed tomography (CT) scan of the abdomen, and colonoscopy, all of which were normal.

A careful history revealed that her abdominal pain occurred 30 minutes postprandially and was not associated with any particular types of food. She had lost 50 pounds over the past six months secondary to pain, but she stated she had not experienced claudication, transient ischemic attacks, or chest pain. Physical exam revealed no bruits, masses, or abdominal tenderness, and her rectal exam was heme negative with no masses. A duplex ultrasound showed a normal superior mesenteric artery and severe stenosis of the celiac artery which was demonstrated by increased velocities (400-500 cm/sec) and wide spectral broadening.

This patient underwent an arteriogram that showed an aorta free of atherosclerotic disease (Figure 1). The renal arteries, superior mesenteric artery and inferior mesenteric artery were also free of disease, but the celiac axis showed severe stenosis (80%-85%) that appeared to be secondary to extrinsic compression (Figure 2).

An abdominal exploration showed that the aorta and native celiac axis were free of gross atherosclerotic disease, but the celiac axis was tightly enveloped by the fibers of the median arcuate ligament (Figure 3). After transection of these fibers, a pressure differential of 15-20 mmHg still existed, so an aortosplenic bypass using an 8-mm polytetrafluoroethylene (PTFE) graft was performed. She did well postoperatively and was discharged home after seven days.

This patient has been followed now for over a year and is currently pain free. She has gained 15 pounds and is able to perform daily activities without problems.

Discussion

Celiac compression syndrome was first described by Harjola in 1963 (3). The syndrome occurs when the median arcuate ligament of the diaphragm and/or periarterial neural tissue causes extrinsic compression of the celiac axis. The median arcuate ligament is formed by the fusion of the crura of the diaphragm on either side of the aortic hiatus, posterior to the origin of the celiac trunk. Since the origin of the celiac trunk migrates caudally during embryogenesis, its final location may vary from the level of the 11th thoracic to the first lumbar vertebra. Therefore, a high origin of the celiac trunk relative to the median arcuate ligament may result in compression of the artery.

Some compression of the celiac trunk by the median arcuate ligament can be arteriographically demonstrated in 10% to 50% of the patients with this condition; however, most patients do not show any clinical manifestations (8,9). Accentuation of the compression during deep expiration can be documented, as well as augmentation of the blood flow through the pancreaticoduodenal arterial system, which compensates for the compressed celiac axis with retrograde flow from the superior mesenteric artery (10).

The exact cause of the pain experienced by patients with celiac

Figure 3. Intraoperative photograph showing the celiac axis tightly stenosed after the fibers of the median arcuate ligament were transected.

compression syndrome remains controversial, and two theories exist to explain it - - the vascular theory and the neurogenic stimuli theory. Physicians who espouse the vascular theory believe the syndrome's pain complex may be related to ischemia secondary to reduced flow or mesenteric steal (2,4). Proponents note the presence of collaterals from the superior mesenteric artery as well as reversal of superior mesenteric artery blood flow in symptomatic patients. The neurogenic theory maintains that the pain originates from the celiac ganglion and its fibers that compress the celiac axis, which is activacted by the continuous pulsations (9).

All patients must have an extensive work-up preoperatively to exclude other causes of abdominal pain and/or weight loss. This evaluation must include upper and lower endoscopy or barium studies, CT scan of the abdomen, and ERCP (2).

Patients who benefit substantially from operative intervention include females between 40-60 years of age who have a weight loss greater than 20 pounds, postprandial pain, and angiographic evidence of poststenotic dilatation or increased collateral flow from the superior mesenteric artery (2). The recommended operative procedure consists of division of the ligament combined with celiac artery dilatation or revascularization. Celiac decompression alone is associated with a 53% long-term cure rate. However, combined with either dilatation or revascularization, the long-term cure increases to 76% (2).

The need for revascularization is strongly recommended if a pressure gradient, persistent thrill, or vessel deformity remains after ligament transection and/or dilatation. The pressure gradients are reduced and usually obliterated by revascularization (2).

Conclusion

The classic triad of celiac compression syndrome consists of abdominal pain, an epigastric bruit, and angiographic evidence of celiac compression. Proper patient selection is crucial for positive, long-term results of operative intervention, which consists of a thorough exploration, transection of the median arcuate ligament, and either dilatation or a bypass.

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Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

Keep the change, Doc!: Coins in the upper GI tract of children

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Abstract

Many children are brought to the Emergency Room each year because they have swallowed foreign bodies (FBs), particularly coins. Whether to remove these foreign bodies or let them pass through naturally is a constant dilemma for ER physicians. This article reviews our experiences in treating pediatric patients who underwent FB retrieval for coins, food particles and toy parts, and discusses their clinical and endoscopic findings. The vast majority (82%) of the swallowed FBs were lodged in the esophagus. A review of the literature and a suggested medical protocol to manage patients who have swallowed coins are also discussed in this article.

Introduction

Many children often swallow objects because they have the natural inclination to put things in their mouths. As a result, foreign body (FB) ingestion is a common diagnosis in the emergency room, and it most often occurs among children 6 months to 3 years of age (1).

Coins are the most common FBs swallowed by children and account for the majority of esophageal FBs (2). In the 1989 annual report of the American Association of Poison Control Centers, a total of 5,185 cases of coin ingestion by children were reported (3). Although most of the FBs will eventually leave the GI tract naturally, parents' apprehension and possible complications play a major role in the ultimate decision to retrieve or not to retrieve the objects.

Indeed, there are no clear guidelines for general pediatricians and other primary caretakers regarding patients who swallow FBs. Should the patient be sent to the Emergency Department (ED) for radiological examination and possible coin removal or is reassurance to the parents all that is needed?

In a survey done in Utah, 77% of the local pediatricians stated they do not routinely obtain a roentgenogram on an asymptomatic child who has swallowed a coin (4), and only about 30% of these patients are examined in a health care facility (5). In other communities, these patients may be sent home with reassurance only.

In this article, we review our experiences in caring for pediatric patients who swallowed coins and suggest a protocol to standardize the medical approach.

Materials and methods

The charts of 46 pediatric patients who were referred to Department of Pediatrics at the Marshall University School of Medicine for FB removal between 1984-1994 were reviewed retrospectively. The male/female ratio was 2.1/1.0 and the mean age was 4.3 years (range: 5 months to 16.5 years). Presenting symptoms and FB location are shown in Table 1.

Coins were found in 31 patients (67%), (Table 2). Flexible endoscopy was performed in 58% of the cases, and rigid endoscopy in 13%. A Foley catheter was used in 16% of the cases. Two different procedures were needed in 13% (rigid + flexible endoscopy in 4% and Foley catheter + rigid endoscopy in 9%).

Of the 46 patients treated, the FBs in 44 of them (96%) were successfully retrieved, and the FBs in the remaining two patients (4%) were pushed into the stomach and passed naturally. No complications occurred.

To further learn the magnitude of FBs in our area, all Cabell-Huntington Hospital ED visits during 1991 were analyzed in retrospect. A total of 55,430 visits were recorded and 54 of these patients (0.1%) were treated for swallowing FBs. A total of 39/54 (78%) were patients under 20 years old, and coins were the major objects found in these patients (Table 3). Thirty-seven of these patients (95%) were discharged from the ER with reassurance, and only two cases required removal.

Discussion

Although children often swallow FBs, the clinical presentation may differ according to age. Older children usually report the accident voluntarily

Table 1. Presenting Symptoms and FB Locations

Symptoms	No.	(%)
"Swallowed a FB"	38	83
Dysphagia	28	61
Vomiting	08	17
Cervical/chest pain	06	13
Choking/cyanosis	05	11
Upper respiratory infection	04	09
Drooling	02	04
Anatomical Locations		
Upper esophagus	12	26
Middle esophagus	18	39
Lower esophagus	08	17
Stomach	08	17

Table 2. Endoscopy Findings

Foreign Body	No.	(%)
Penny	19	42
Nickel	04	09
Dime	02	04
Quarter	06	13
Paint chip	01	02
Thumbtack	01	02
Iron pills	01	02
Toy plastic chips	02	04
Food (meat)	09	20
Metal spring	01	02
Total	**46**	**100**

Table 3. Foreign Bodies* Swallowed by Patients Who Were Discharged from the Cabell Huntington Hospital ED (1991)

Foreign Body	No.	(%)
Coin	11	30
Metal	06	16
Toy	05	13
Glass	03	08
Battery	01	03
Wood	01	03
Food	04	12
Unknown	06	16
Total	**37**	**100**

*In patients less than 20 years old

to their parents; in small children, accidents may be discovered only by suspicious parents. Even though most patients seek medical attention within 24 hours of ingestion, asymptomatic patients or patients with non-specific symptoms may delay diagnosis up to several months (6-8). Our patients presented with symptoms similar to those reported previously (4,9-11), i.e., dysphagia, drooling, choking, vomiting, and pain.

In symptomatic patients, the coin is usually lodged at one of three esophageal sites: the crycopharyngeus, the middle third (left main bronchus notch), and the esophageal-gastric junction. In patients after esophageal operations or patients with esophageal stricture due to chronic reflux esophagitis, the coin will lodge at the narrowed area.

In our patient population, most of the coins were lodged in the upper or mid-esophagus (67%), and only 15% were lodged in the stomach. All patients with coins in the esophagus were symptomatic, and FBs were removed upon arrival. FBs in the stomach were removed either because they had failed to pass through or were considered dangerous to the GI tract (i.e., sharp objects). One patient who swallowed a coin into his stomach was free of symptoms until he vomited forcefully and lodged the coin in his mid-esophagus.

Although esophageal complications due to coin impaction have been reported (6,7,9,12), spontaneous passage through the esophagus within 24 hours has been documented (4,13). Thus, a 24-hour observation period in asymptomatic patients is safe and may spare discomfort and risk of endoscopy.

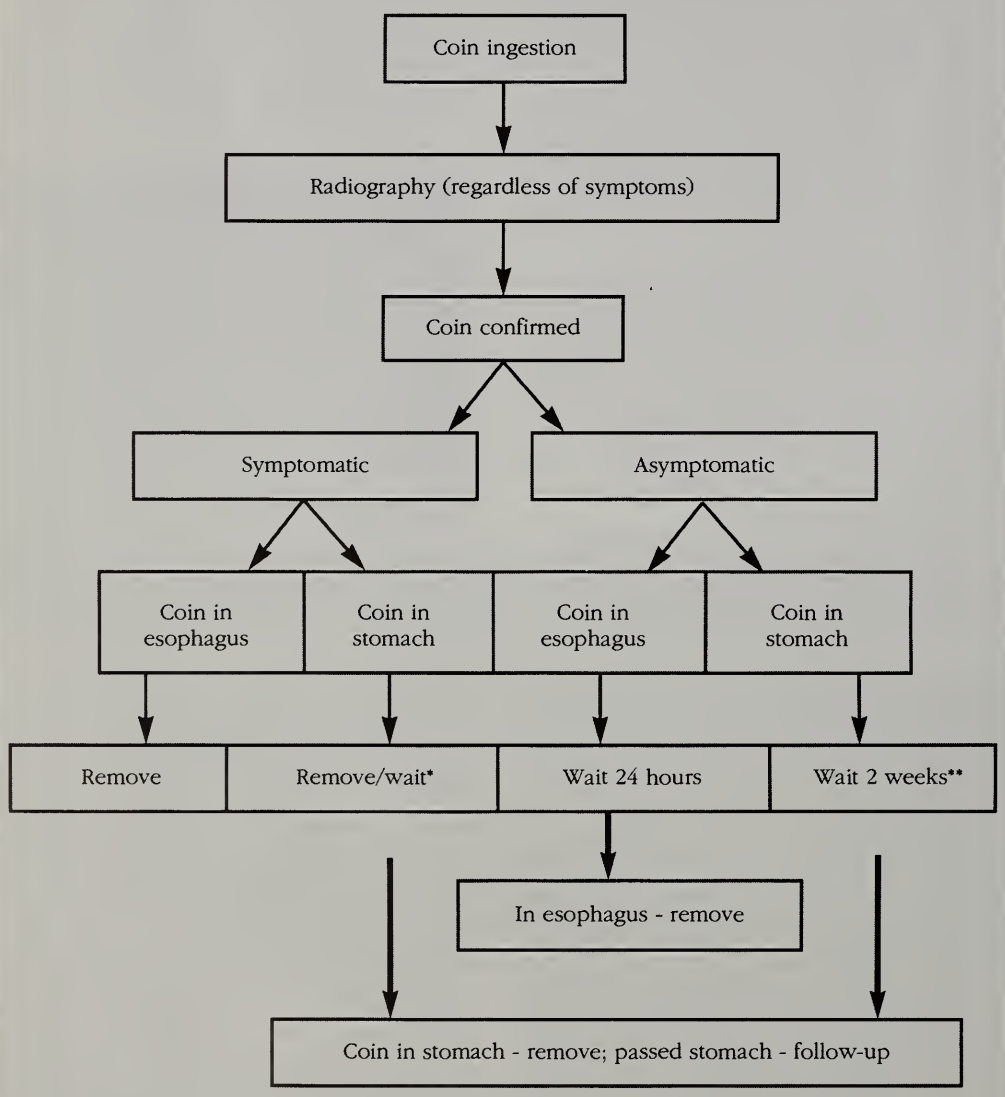
Coins in the stomach are more likely to pass through, and unless symptomatic, radiological follow-up (AP and lateral abdominal telus) is recommended. Large studies of children who swallowed coins showed that coins which pass beyond the cardia are unlikely to cause complications (2,13,14). The duration of radiologic follow-up is controversial, but most agree that it should be at least two weeks.

Coins have been extracted from the gastrointestinal tract in several ways. According to their medical resources, each community commonly retrieves coins by Foley catheter under fluoroscopy (performed by a radiologist); by direct rigid endoscopy (performed by an ENT specialist); or by flexible endoscopy (performed by a gastroenterologist). Rigid endoscopy is limited for FBs lodged in the oropharynx or proximal esophagus. There is need for particular caution when the Foley catheter is used, and contraindications for this method exist, including edema of the esophageal wall, unusual size or shape of the FB, and the time lapse since the FB was swallowed (15). Flexible endoscopy, although more expensive, is a safer procedure that provides the best success rate in retrieving coins (4).

The management of coin ingestion in children varies from community to community, reflecting differences in facilities, resources, geographic location, and medical access. Due to the rural nature of many West Virginia communities and because few pediatric gastroenterologists practice in this state (only two in 1994), we suggest the algorithm shown in Figure 1, which is modified from reference 13.

Every child who swallows or is suspected of swallowing a coin should be sent for X-ray examination (chest and abdomen) whether or not they have symptoms. Once a coin is identified in asymptomatic patients, a waiting period of 24 hours is suggested for coins lodged in the esophagus, and of up to two weeks for coins lodged below the cardia. Esophageal coins identified on X-ray after 24 hours from ingestion should be retrieved. Coins in the stomach should be followed by abdominal X-ray every 5-7 days for two weeks or until passed naturally. In patients who fail to pass the coin after two weeks, a decision for retrieval is made upon the individual circumstances, including

Figure 1. Algorithm for Patients Who Swallowed a Coin



*Practice differs from center to center
**Waiting period with radiography follow-up

parent apprehension and the availability of local medical resources.

In symptomatic patients, esophageal coins should be retrieved immediately to prevent complications. The treatment of symptomatic patients with a coin in the stomach is controversial. It is our practice to retrieve those coins at the first visit.

It is clear that only a small fraction of cases with FBs in the GI tract require retrieval. Retrospective analysis of patients who visited the Cabell Huntington Hospital ED during 1991 showed that 95% were discharged from the ED with reassurance and, in only two cases, was removal of the FB necessary. Although no follow-up on the discharged patients is available, it is assumed that they passed the FB naturally.

Conclusion

In summary, we report our experiences with FBs in children and discuss the different approaches to children who swallowed coins incidentally. We suggest an algorithm for the West Virginia primary care physicians to follow in such cases. Early detection and standard treatment will eventually be safer and less expensive for children and their families.

Acknowledgement

We would like to acknowledge Mrs. Jennifer Long for her excellent secretarial assistance with this manuscript.

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Acute renal failure due to ofloxacin

JULIAN ESPIRITU, M.D., FACP
Assistant Professor, West Virginia School of Medicine, Charleston Division, Charleston

TED WALTON, PHARM.D., BCPS
Charleston Area Medical Center, Department of Pharmacy and Drug Information, Charleston

Abstract

Fluoroquinolone antibiotics have rarely been associated with renal failure (1). However, temafloxacin, a member of this drug class, was voluntarily withdrawn from the U.S. market in 1992 after reports of renal failure and other adverse reactions (2). In this article, we report one of the first published cases of renal failure resulting from the administration of ofloxacin (Floxin®, Ortho Pharmaceutical Corporation), one of the newest fluoroquinolone antibiotics.

Introduction

Rarely have fluoroquinolone antibiotics been associated with renal failure (1). However, a member of this drug class, temafloxacin, was voluntarily withdrawn from the U.S. market in 1992 after reports of renal failure and other adverse reactions (2).

Although adverse reactions with these agents is rare, it is an event for which patients should be closely monitored. In this article, we report one of the first published cases of renal failure resulting from the administration of ofloxacin (Floxin®, Ortho Pharmaceutical Corporation), one of the most recent additions to this class of antibiotics.

Ofloxacin is frequently prescribed for a wide range of infections, including prostatitis (3), but there has been only one previous report of acute interstitial nephritis in a patient who was receiving this medication (4). However, interstitial nephritis has been reported with other fluoroquinolones such as ciprofloxacin (5).

Case report

A 67-year-old male with a history of cerebrovascular accident, hypertension and renal insufficiency (pre-treatment creatinine clearance = 0.52 ml/sec {31 ml/minute}) was admitted to the Charleston Area Medical Center (CAMC) with uremia and acute renal failure. His history revealed that about three months earlier, he had been seen and treated by a private physician and diagnosed with prostatitis for which antibiotic therapy with ofloxacin 300 mg po twice daily was initiated. Approximately two weeks into a six-week course of treatment, this patient had noted a pruritic "pimple-like" localized rash on his forehead and the side of his face, but he experienced no fever, chills or flank pain. This rash resolved after completion of oxfloxacin therapy.

Shortly after the treatment period, he developed shortness of breath and nausea and was admitted to a hospital, where it was noted that his blood urea nitrogen (BUN) was 42 mmol/L (117 mg/dl) and creatinine 1008 Mmol/L (11.4 mg/dl). He was then transferred to CAMC for treatment of his renal dysfunction and possible dialysis.

Upon evaluation, this patient showed a BUN of 42 mmol/L (119 mg/dl), creatinine 1114 Mmol/L (12.6 mg/dl) with 9% eosinophils and 3% urine eosinophils. Sedimentation rate was 86 mm/h; antinuclear antibody was positive with a titer of 320, but double-strand DNA was < 10. An ultrasound study showed normal size kidneys and was negative for hydronephrosis, mass lesions and calculi. A renal scan revealed marked flattening and elevation of the excretion curves consistent with bilateral decreased function.

Corticosteroids and hemodialysis were initiated, and he was dialyzed for about one week with no improvement. A renal biopsy was performed which showed resolving interstitial nephritis with the occasional presence of eosinophils in the interstitium and marked arteriolonephrosclerosis. He had slow resolution of renal function and required further hemodialysis.

This patient died after approximately two weeks of dialysis. An autopsy revealed a ruptured thoracic aortic aneurysm.

Conclusion

We recommend discontinuing fluoroquinolones if a patient develops a rash and monitoring renal function to rule out concurrent renal dysfunction, instructions which are listed in the labeling of these medications (3). Patients should be counseled to report any rash that develops during therapy since the skin lesions may be very atypical as in this case.

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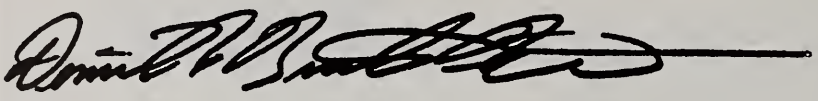
Contributions for WESPAC/AMPAC are not deductible as charitable contributions for federal income tax purposes. A portion of your WESPAC contribution is sent to AMPAC, thus enrolling you as an AMPAC member as well.

President's Page



Charleston follies begin

Once again, it's that time of year. The 1995 West Virginia State Legislature is now in session. Since 1989 (remember S.B. 576?), this annual travesty has produced much consternation for us. However, this year we are in a much stronger position than in the past for several reasons.

First of all, my immediate predecessors, as well as myself, have made political involvement and legislative action a top priority. Due to our efforts, the WVSMA is much more effective and involved. We periodically meet and discuss medical issues with the leadership of the Legislature and the Caperton administration. This has increased not only our visibility, but our credibility as well. Legislative leaders now understand that we are willing and able to tackle complex health care issues and try to arrive at reasonable solutions.

Secondly, our longstanding relationship with our lobbyists, Perry and Haid, as well as the stability of our in-house legislative specialists, George Rider and Winnie Morano, has enabled us to produce a more seamless and efficient approach to legislative problems. In addition, the leadership of the WVSMA has worked hard to present a more unified front on medical issues, thereby decreasing confusion amongst legislators.

Thirdly, the makeup of the Legislature is more conservative than in the past, and there are now three physician members (one senator and two members of the House of Delegates). Also, the leadership and some individual members have become more knowledgeable about health care issues, which has enabled them to understand our concerns more easily.

And lastly, but most importantly, we have an excellent legislative agenda which includes the following:

(1) Our version of the AMA Patient Protection Act, which protects physicians <u>and</u> patients from abuses by the managed care entities invading our practices,

(2) An economic credentialing bill to prevent hospitals from linking privileges to economic issues rather than quality of care,

(3) A Medical Savings Account bill to make patients more responsible for their health care expenditures; and

(4) Tort reform focusing on the areas of collateral source, meritorious claims screening, periodic payments, sliding fee scale for plantiff attorneys, and reduction in the statute of limitations from 10 to six years.

All of these factors, plus the strong commitment and dedication of the WVSMA leadership, staff and myself to the legislative process puts us in the best possible position to effect productive changes for health care in West Virginia -- changes that will benefit not only physicians, but our patients as well. I look forward to this challenge and your unwavering support with great anticipation.

Dennis M. Burton, M.D.

HMO business

According to a number of recent reports, HMO stockholders are now getting rich. Hence, one might be led to conclude the logical correlative -- doctors are now getting poor. The correlative, however, is not entirely true.

Unfortunately, what is true is that patients, the HMO subscribers, get no benefit from the ratcheting down of hospital costs and medical care fees extorted by HMOs in their "negotiations" with "providers of care." What they do get is a reduction in benefits coerced through their "providers" by the onerous system of fines and shameful bonuses forced upon the "providers" as a condition of participation in the plan.

There can be little question that doctors participating in HMO plans are the frequent victims of feelings of shame and frustration at the necessity of knuckling under to the "carrot and stick" of such systems. This is especially true when the treatment edicts are laid down by a "case manager" who, never having seen the patient involved, relies on some financial table of costs to make a treatment decision involving the patient's life and the reputation of the doctor.

The CEO of one large HMO is reported to have made $9.8 million in salary last year in addition to $11.4 million in dividends from the 15 million shares of stock he personally owns. Along with the rapid increase in size and profitability of HMOs, there has occurred a simultaneous decrease of 12% to 20% in fees paid to specialists and hospitals.

We do not cite these figures in the way of a complaint. We recognize and rejoice in the fact that we are a part of a free enterprise system and must take our lumps along with our rewards. The problems ordinary citizens have in dealing with medical care costs, however, are unlikely to be mitigated by interposing the needs of stockholders and bottom line ambitions of HMO executives.

Doctors are hardly in the position of factory workers in need of union and Fair Employment Practice Administration protection, but some physicians have expressed concern about their lack of rights in HMOs. The big thinkers in health care systems now fairly consistently regard the provision of health care as they do the provision of any other product -- toothpaste, tomato soup, automobiles, airplanes, ashcans, etc. As a result of such thinking, it is not too farfetched to picture doctors, nurses, aides, various technicians and even hospital administrators slogging off to the health care factory clutching their lunch buckets.

HMOs seem firmly entrenched in the Northern Panhandle of West Virginia. We have heard no claims of any consequent startling reductions in health care costs in that part of the state, which should apparently not be too surprising with the revelations we have already mentioned. HMOs are also making determined efforts at "market penetration" in other parts of West Virginia. We shall watch their success, or lack of it, with some curiosity.

– Stephen D. Ward, M.D.

Our Readers Speak

Special praise for Dr. Craig Morgan

In this era of excessive malpractice suits and constant debate about health care reform, I want to applaud my doctor, Craig M. Morgan, M.D., of Huntington, for the outstanding care he has given me.

I was referred to Dr. Morgan by my optician, Colan Sturgeon, after seeing him for contact lenses and explaining some problems I was experiencing with my eyesight. Immediately upon referral from Mr. Sturgeon, I was seen by Dr. Morgan, who discovered a retinal detachment in my right eye and three retinal tears in the left eye. By the way, I am a poet and teacher and was underinsured; however, this did not present a holding pattern for the doctor. His premise was that this operation must be performed immediately or a loss of vision could possibly occur.

Dr. Morgan's office staff is an extension of his warm and friendly personality, ideally coupled with efficiency and organization, plus direct, honest evaluative processes conducted therein. The receptionists, the nurses, the technicians, and yes, even the financial assistant each reflect one message . . . the utmost concern and care of the "**patient**."

I have often wondered if this expediency would have happened in Canada or England. Also, would I have been blessed with such a brilliant, skilled and talented physician who would have had the knowledge, fortitude and decisiveness to proceed posthaste with the operation?

Sandra L. Harman
Logan

Money the key factor in access to care

"In any situation anywhere there is always a key fact, the essence. But it is usually every other fact, thousands of facts, that are seen, discussed, dealt with. The central fact is usually ignored, or not seen."

Doris Lessing
The Fourgated City

In regards to the article entitled *"Access to Medical Care in West Virginia: Implications for Policy"* which appeared in the November issue, the key fact in West Virginia is that people don't have money for medical care and many of them are living in out-of-the-way places, often without a car or telephone. If this fact isn't addressed, then people will not go for medical care they cannot afford unless they are so sick that they are prepared to seek some form of charitable care.

This explains why the statistics for serious illness and life-threatening conditions are quite good in West Virginia, but there are concerns about prevention and primary care, as well as concerns about the lack of readily available health care workers in places where they cannot make a reasonable living. The policy implications are: community development; sending young workers away to send money home; and/or keeping up public health with physicians' salaries being paid by outside agencies, etc., instead of individuals in the communities where they would practice.

Most of the planned health care reforms miss the point, many are a waste of time, and many will just add more bureaucracy. It is probable that in doing so they will also reduce the availability of medical and hospital care by reducing income, thereby making practicing less attractive and viable.

R. John C. Pearson
Professor and Chairman
WVU Department of Community Medicine
Morgantown

Mark Your Calendars!!
Please Attend

The 1995
WVSMA Legislative
Briefing & Reception

at the Charleston Marriott
Wednesday, February 8

Briefing - 5 - 6:30 p.m.
Reception - 6:30 - 8 p.m.

Please R.S.V.P. by February 3
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At Mid-Winter

Postoperative/terminal pain, TB, outcome studies, otitis media featured topics for Fourth Session

Four subjects currently affecting patient care will be highlighted for the Fourth Scientific Session, *"Potpourri of Topics,"* which will be the concluding event on Sunday, January 22 at 9 a.m. for this year's WVSMA/WV-ACP's 1995 Mid-Winter Seminars and Scientific Conferences at the Radisson Hotel in Huntington.

This session will kickoff with a lecture on *"Pain Control, Assessment and Treatment: Postoperative and Terminal"* by **Charles S. Cleeland, M.D.**, a professor of neurology and director of the Pain Research Group at the University of Wisconsin Medical School in Madison, Wis. Immediately following, **Charles L. Hyman, M.D.**, an assistant clinical professor in the Infectious Diseases Division of the SUNY Health Science Center in Brooklyn, N.Y., will speak on the subject of *"Multi-Resistant TB."*

After a break from 10 a.m. - 10:30 a.m., the third presentation, *"Outcome Studies and Guidelines,"* will be delivered by **Elizabeth L. Spangler, M.D.**, director of medical affairs at the Charleston Area Medical Center in Charleston. The concluding lecture for this session, *"Facing the End of the Antibiotic Era -- The Impact of Resistance on Otitis Media,"* will then be presented by **Michael Poole, M.D., Ph.D.**, an associate professor of otolaryngology at the University of Florida School of Medicine in Gainesville.

Information about these speakers begins below. Registration for this session will begin at 8:30 a.m. that morning, or you may register by phoning the WVSMA Registration Desk at the Radisson Hotel at (304) 525-1001.

Cleeland

Spangler

Poole

Lecturers highlighted

Dr. Cleeland received a Ph.D. degree in psychology from Washington University in St. Louis in 1966, and then served as a NIH Postdoctoral Fellow at the University of Wisconsin Department of Neurology.

After his fellowship, Dr. Cleeland joined the University of Wisconsin faculty as an assistant professor of neurology, and in 1972, he was promoted to associate professor. While he was an associate professor, Dr. Cleeland worked for a year as director of the Pain Management Unit at the University of Wisconsin Hospital, and in 1979, he accepted his current role as director of the Pain Research Group at the University of Wisconsin Medical School. In addition to this post, Dr. Cleeland has been a full professor at the University of Wisconsin since 1984, and he has been director of the World Health Organization's Collaborating Center for Symptom Evaluation in Madison for the past seven years.

A noted researcher, Dr. Cleeland is presently involved in several pain management studies for the NIH, the Department of Defense, the American Cancer Society, the Bristol-Myers Squibb Foundation and the Robert Wood Johnson Foundation. He has written over 75 book chapters and articles and is a contributing editor for the *Journal of Pain and Symptom Management* and *Health Psychology.*

Dr. Cleeland is a diplomate of the American Board of Professional Psychology and a fellow of the American Psychological Association. He is chair of the U.S. Cancer Pain Relief Committee and is also president-elect of the American Pain Society.

Dr. Hyman received his M.D. degree in 1984 from The Sackler School of Medicine, the New York State Program of Tel Aviv University, which is located in New York City. He completed his internship and residency in internal medicine at Kings County-Downstate in Brooklyn, where he then served as a fellow in infectious diseases.

In 1990, Dr. Hyman was named director of Firm B for the Kings County Hospital Center, and he joined the faculty of the SUNY Health Science Center at Brooklyn as an assistant clinical professor in the Infectious Diseases Division, a post he still holds today. In addition, since 1992 Dr. Hyman has also been director for clinical affairs and co-director of the Department of Medicine at Kings County Hospital Center.

Dr. Hyman has written several articles and abstracts pertaining to infectious diseases. He is a member of the American Society of Microbiology and the Infectious Diseases Society of America.

Dr. Spangler graduated first in her class from the Mercy Hospital School of Nursing in Springfield, Mass., in 1959. She then worked for three years as an operating room staff nurse at Wesson Memorial Hospital, which is also located in Springfield.

In 1962, Dr. Spangler relocated to Charleston, W.Va., and accepted a

position as an operating room staff nurse in Charleston Memorial Hospital, which is now a division of CAMC. The following year, she began working as a private surgical nurse, specializing in vascular and general surgery. In 1965, Dr. Spangler returned to Charleston Memorial Hospital to serve as an instructor in operating room technology, and two years later she was promoted to head nurse of nursing services and in-service education for the operating room at CAMC. She held this post for seven years and during this time began her pre-med studies.

From 1974-76, Dr. Spangler was supervisor of obstetric and neonatal nursing for CAMC, and she was then elevated to the post of director of emergency services for CAMC's Memorial Division. In 1979, Dr. Spangler left CAMC to work as director of nursing services for the Eye and Ear Clinic of Charleston, Inc., where she was on staff until 1982, when she was accepted into the Marshall University School of Medicine.

After graduating with her M.D. degree from Marshall University in 1986, Dr. Spangler completed a three-year residency in internal medicine at CAMC, and then assumed her current post as director of medical affairs for CAMC. In addition to her role at CAMC, Dr. Spangler is a volunteer physician for the West Virginia Health Right Clinic in Charleston.

Certified by the American Board of Quality Assurance and Utilization Review Physicians and the American Board of Internal Medicine, Dr. Spangler is also a diplomate of the National Board of Medical Examiners.

Dr. Poole is a native of Charlotte, N.C., who was on active duty with the U.S. Army from 1971-75. During this time he also attended Infantry Officer Candidate School and was a distinguished honor graduate, and he also received a B.A. degree in history from Fayetteville State University in Fort Bragg, N.C.

In 1975, Dr. Poole returned to Charlotte to attend the University of North Carolina, where he obtained an M.S. degree in biology in 1978, and was then accepted into the School of Medicine. After receiving his M.D. degree in 1981, Dr. Poole remained at UNC to complete an internship in general surgery and a residency in otolaryngology, and also obtain a Ph.D. in microbiology.

While he was working on his doctorate in microbiology, Dr. Poole relocated to Tallahassee to join a private ear, nose and throat practice, where worked until last year when he joined the faculty of the University of Florida School of Medicine as an associate professor of otolaryngology. In addition to his role on the University of Florida faculty, Dr. Poole is serving as director of the Southeastern Clinical Otolaryngology Research Group.

A world renown speaker, Dr. Poole has made nearly 100 presentations at medical meetings in the U.S. and abroad. He is also a noted author who is the editor of the Infectious Disease Section of the *Ear, Nose, and Throat Journal.*

Dr. Poole is board certified by the American Board of Otolaryngology, and is also certified in American Trauma Life Support and Advanced Cardiac Life Support. He is a fellow of the American College of Surgeons and is currently serving as the commander of the 1878th Head and Neck Surgical Team in Jacksonville, Fla.

Survey concerns Office Managers Association

The Office Managers Association of Health Care Providers, Inc, (OMA) has been working very closely with the WVSMA preparing for this session of the Legislature. During a recent committee meeting, the OMA was requested to survey its members to determine the percentage each third party payor repesented out of their physician's total patient population.

While this data was being compiled, the OMA learned that approximately 45 percent of the 202 respondents were not computerized. In addition, many of these practices were unable to complete the survey because they were not practicing an adequate form of recordkeeping which would allow them to identify their payors and the percentage of business generated.

The WVSMA and OMA are very concerned about these survey results, so the OMA will soon be offering a workshop on how to computerize your medical practice. In addition, the OMA is offering a skills training program which is described in the box below.

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Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

Robert C. Byrd Health Sciences Center of WVU - Charleston

February 2
(Teleconference) "Opportunistic Infections in HIV Patients," Elizabeth A. Funk, M.D.

February 16
(Teleconference) "Obstetrical Ultrasound: Tips and Techniques," David A. Chaffin, M.D.

Robert C. Byrd Health Sciences Center of WVU - Morgantown

January 27-29
"2nd Annual Critical Care to Rehabilitation Conference: A Pulmonary Focus" (sponsored by the WVU School of Medicine, Dept. of Medicine, and MountainView Regional Rehabilitation Hospital), Snowshoe Resort, Snowshoe

January 27-29
"Advanced Life Support for Obstetrics" (sponsored by the WVU Dept. of Family Medicine and Preston Memorial Hospital), RCBHSC, Morgantown

January 27
"The Ethics and Law in West Virginia of Health Care Decision Making for Incapacitated Patients" (sponsored by the WVU Center for Health Ethics and Law), Days Inn, Flatwoods

West Virginia State Medical Association - Charleston

January 19-22
WVSMA/WVACP's Mid-Winter Seminars and Scientific Conferences, Radisson Hotel, Huntington

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

□ *CAMC/Robert C. Byrd Health Sciences Center of WVU, Charleston*

Fairmont ★ Fairmont Clinic, Feb. 15, 1 p.m., "Juvenile Diabetes," Evan Jones, M.D.

Gassaway □ Braxton County Memorial Hospital, Feb. 6, 6:30 p.m., "Recent Advances in Anti-Infective Therapy," Christine Teague, Pharm. D.

Logan □ Logan General Hospital, Feb. 3, 11:45 a.m., "Sleep Disorders," George Zaldivar, M.D.

Man □ Man Appalachian Regional Hospital, Feb. 15, 6:30 p.m., "Suicide Assessment and Prevention," Tom Ellis, Psy.D.

Montgomery □ Montgomery General Hospital, Feb. 1, 12:30 p.m., "Risk and Indications of Blood Transfusions," Mary Taylor, M.D.

Oak Hill □ Plateau Medical Center, Jan. 24, 6:30 p.m., "Treatment of Osteoporosis," Alfred K. Pfister, M.D.

Parkersburg ★ Camden-Clark Memorial Hospital, Feb. 8, 7:30 a.m., "Antibiotic Allergies in Children," Nevin Wilson, M.D.

★ Camden-Clark Memorial Hospital, Feb. 22, 7:30 a.m., "Applying Basic Immunology to Clinical Practice," Paris T. Mansmann, M.D.

Philippi ★ Broaddus Hospital, Feb. 2, 1 p.m., "Seizure Management," Raj Sheth, M.D.

Point Pleasant □ Pleasant Valley Hospital, Feb. 23, noon, "TMJ," Kent Jackfert, D.D.S.

Richwood □ Richwood Area Medical Center, Feb. 9, 5:15 p.m., "Cancer Prevention Screening," Arvind Kamthan, M.D.

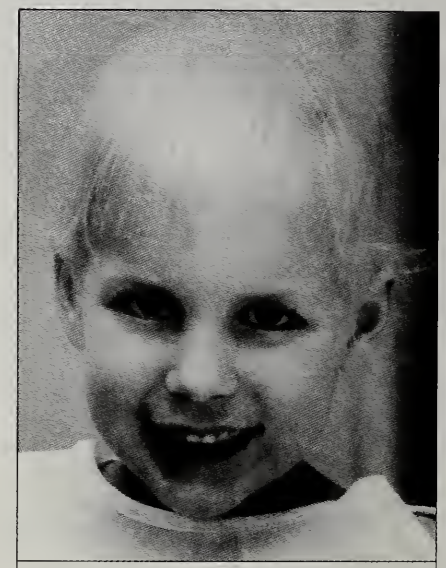
Ripley □ Jackson General Hospital, Feb. 10, 12:30 p.m., "Suicide Assessment and Prevention," Tom Ellis, Psy.D.

Spencer □ Roane General Hospital, Feb. 21, 12:30 p.m., "Recent Advances in Anti-Infective Therapy," Christine Teague, Pharm.D.

Waynesburg, Pa. ★ Greene County Memorial Hospital, Feb. 14, 7 p.m., "Assessment of Abdominal Injuries," Laurel Omert, M.D.

White Sulphur Springs ★ The Greenbrier Clinic, Feb. 27, 4 p.m., "The Red Eye," Mark Mayle, M.D.

Williamson □ Williamson Appalachian Regional Hospital, Jan. 26, 6:30 p.m., "Alcohol Withdrawal Syndromes," James Griffith, M.D.



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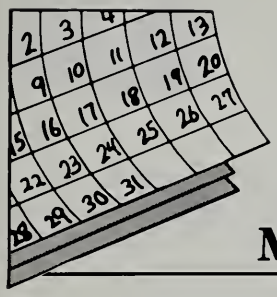


Medical Meetings

February

5-8–Southern Surgical Congress, New Orleans

6-8–Cardiovascular Conference at Snowshoe (sponsored by the American College of Cardiology), Snowshoe, W.Va.

9-12–50th Annual Postgraduate Ob/Gyn Assembly (sponsored by the Ob/Gyn Assembly of Southern California), Beverly Hills, Calif.

11-18–Super EMG XVI (sponsored by Ohio State University), Kohala Coast, Hawaii

16-19–American Academy of Pain Medicine, Palm Springs, Calif.

16-21–American Academy of Orthopaedic Surgeons, Orlando, Fla.

18–Third Annual Pulmonary Infections Symposium: Critical Care Medicine for the Primary Care Physician (sponsored by Ohio State University), Columbus

20-22–Cardiopulmonary Rehabilitation Symposium: Status '95 (sponsored by the University of Florida), Orlando, Fla.

22-25–The 2nd International Conference on Advances in the Biology and Clinical Management of Melanoma (sponsored by the University of Texas M.D. Anderson Cancer Center), Houston

February 24-March 1–American Academy of Allergy and Immunology, New York City

February 27–March 2–The Alton D. Brashear Postgraduate Course in Head and Neck Anatomy (sponsored by Virginia Commonwealth University), Richmond

March

4-9–22nd Annual Critical Care Medicine Course (sponsored by the University of Oklahoma), Oklahoma City, Okla.

4-5–Liver Disease in Hemophilia: New Directions in Diagnosis, Management and Treatment (sponsored by George Washington University), Atlanta

4-5–38th Annual Postgraduate Symposium in Ophthalmology: Bread and Butter Neuro-Ophthalmology (sponsored by Ohio State University), Columbus

5-10–Fourth Annual Cardiovascular Disease Symposium -- The High Risk Patient: An Interspeciality Approach (sponsored by Ohio State University), Columbus

9-11–Children's Defense Fund's Annual National Conference, Seattle

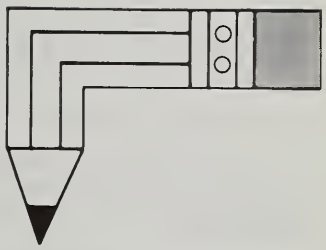
9-11–Symposium for CLIA '88 Laboratory Directors (sponsored by the National Laboratory Training Network, Southeastern Office), Wild Dunes, S.C.

9-12–SEC Sports Medicine Symposium (sponsored by SMA), Atlanta

For More Information . . .

Contact the Journal at (304) 925-0342.

Poetry Corner



The Retirement Game

Perhaps you think retirement is
The next best thing to heaven,
But many days my wife and I
Are out of bed by seven.

We rush to put our clothing on,
We don our socks and shoes,
And quickly gulp our breakfast down
As we read the morning news.

Our eye is often on the clock
To keep from being late.
We've scheduled a mixed doubles match
That starts at half past eight.

The game is rough, we play three sets
Which took a couple hours.
We've barely time to hurry home,
Stretch out, then hit the showers.

The afternoon is busy too,
Our schedule keeps us hopping.
We gulp down lunch and hit the road
To do our daily shopping.

Some days it's hot and we work hard
At trying to keep cool.
It often means for several hours
We're splashing in our pool.

Then dress again, third time today,
Especially if we want
To go and have our dinner out
In our favorite restaurant.

Then hurry up to get back home.
The traffic sure is slow.
You know we wouldn't want to miss
Our favorite TV show.

Some days we have to clean the house
And straighten out our stuff.
I'm telling you retirement
Can actually be quite rough.

Tomorrow we're going to see the doctor.
Today we're seeing the dentist.
Yesterday we were proselytized
By a Seventh Day Adventist.

Today I'll try to read a book.
Oh shucks, there goes the phone!
It seems that those retirees
Will not leave us alone.

Let's play some bridge, let's take a walk.
The pressure never ends.
There's just too many things to do
When you have retired friends.

At times we have so much to do
That I think we'll go berserk.
Unless retirement settles down
I may go back to work.

Harold L. Saferstein, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Bureau for Public Health News

This page of material is submitted and paid for by the Bureau for Public Health.

Hospital discharge statistics highlighted

A new report entitled "*West Virginia Hospital Discharges 1992 Provisional Data*" examines patient origin data for patients discharged from hospitals in the state during 1992. This report is a cooperative effort between the WV Bureau for Public Health, the Center for Rural Health Development, the Health Care Cost Review Authority and the WV Hospital Association.

The first extensive look at hospital discharge data in a number of years, this report provides basic information on where West Virginians received their hospital inpatient care in 1992. It is a valuable resource for health services researchers and others looking at the status of acute care hospital inpatient services.

The tables and maps in the report reflect data for in-state and out-of-state residents discharged from West Virginia hospitals and for West Virginians discharged from out-of-state hospitals under Medicare. The state residents discharged from out-of-state hospitals under other payors are not included in the report, because only partial data on those residents would be available since all states do not report complete discharge information. In addition, the discharges for long-term care are also not included, but the report does include chemical dependency and medical rehabilitation discharges.

Health information like that in this report will play a major role in future health care reform. A greater use of discharge information will be made in the future to analyze variations in such areas as utilization, outcomes, and costs associated with practice patterns. Payors and consumers of health care will also be interested in reports of this nature because they analyze outcomes, cost-effectiveness, quality of care and other issues.

For more information, or for a copy of the report, contact Dan Christy at the Center for Rural Health Development at (304) 558-0530.

National survey states more mothers are breastfeeding babies

The number of mothers who are breastfeeding their babies increased nationally for the third consecutive year in 1993, according to a survey by Ross Laboratories. Officials with the West Virginia Bureau for Public Health's Women, Infants and Children's (WIC) Program say the number of women breastfeeding in West Virginia also is continuing to rise.

According to the national survey, the number of breastfeeding mothers has risen steadily from 1991 through 1993. Almost 56% of mothers responding to the survey breastfed in the hospital immediately after birth, and 19 percent were still breastfeeding when the baby was six months old.

While no statewide data is available for West Virginia, the state's WIC Program does track breastfeeding rates for its participants. Reports show that nearly 35 percent of the women utilizing WIC services breastfeed in the hospital, while almost 12 percent continued breastfeeding until their babies were about six months old. The WIC Program has already met a year 2000 goal it set in 1990 which was to increase breastfeeding among participants by 10 percent.

The national survey found that, unfortunately, rates of breastfeeding among WIC participants continues to lag behind the rates of women not in the program. This may be due in part to low rates of breastfeeding among lower-income women generally.

State and national health experts promote breastfeeding as the best feeding method for just about all infants because a mother's milk is the healthiest food for most babies since it provides essential nutrients for growth and natural immunities from many illnesses. But experts also advise that the close contact between mother and child that also comes with breastfeeding has shown to provide improved emotional development for these children, as well. Breastfeeding promotion emphasizes the ease and benefits of nursing young children.

The WIC Program has encouraged hospitals to increase assistance to new mothers who choose to breastfeed. After hospital discharge, mothers can often get help from hospital phone help-lines, WIC Program breastfeeding counselors available in every county, local La Leche Leagues, and from the growing number of certified lactation consultants in West Virginia who work for hospitals, primary care centers, the WIC Program or physician groups.

For more details, call Connie Neuner of the WV WIC Program at (304) 558-0030.

New program created to improve health of teachers, students

State health and education officials are working together to improve the health status of West Virginia students and teachers through a new project called the West Virginia School Health Initiative, which is funded in part by a grant from the Claude Worthington Benedum Foundation.

As part of this project, 14 counties will house health care clinics in their schools by next year. Health centers will be established at schools in Boone, Cabell, Calhoun, Fayette, Hardy, Kanawha, Lincoln, Marion, Monongalia, Nicholas, Pendleton, Raleigh, Ritchie and Webster Counties to provide preventive and primary care services for students and faculty.

In addition to establishing the school-based health centers, the project calls for the continuation of the West Virginia Healthy Schools Program in Clay, Hardy, Harrison, Ritchie and Webster Counties, and new support for such programs in Cabell, Doddridge, Lincoln, Monroe and Tucker Counties. These programs provide instruction and services in staff health and wellness promotion, health education, physical education, health services, nutrition services, counseling and social services, healthy school environments, and parental and community involvement.

Benedum is contributing about 650,000 to the entire initiative, while the Department of Education will provide a matching $180,00, and the Bureau is contributing $330,000.

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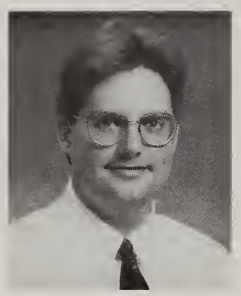
ROBERT C. BYRD HEALTH SCIENCES CENTER
OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

New ophthalmology directors named

Reed


Ellis

Dr. Janis E. Reed has been named the new director of the Department of Ophthalmology's glaucoma service, and Dr. Brian D. Ellis will be the new director of the department's neuro-opthalmology service.

Dr. Reed is a graduate of the WVU School of Medicine, who completed an internship and residency in ophthalmology at St. Francis Medical Center in Pittsburgh, and then served a fellowship at the New England Glaucoma Research Foundation in Boston. Prior to coming to WVU, Dr. Reed was in practice with the Everett and Hurite Ophthalmic Association in Pittsburgh, where she specialized in glaucoma and cataract surgeries.

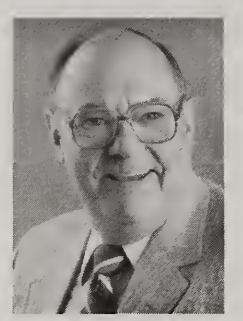
Dr. Ellis is a graduate of the Temple University School of Medicine in Philadelphia, who completed an ophthalmology residency and neuro-ophthalmology fellowship at The Cleveland Clinic Foundation. At WVU, Dr. Ellis will treat patients with complex visual disorders, provide comprehensive ophthalmology services and perform cataract surgeries.

Breast cancer study resumes at Mary Babb

The Mary Babb Randolph Cancer Center is again enrolling participants in the National Cancer Institute's Breast Cancer Prevention Trial.

For more details, phone 293-3515.

Glover re-elected to Pharmacopeia post


Glover

Dr. Douglas Glover, professor of obstetrics and gynecology, has been renominated to serve a five-year term as a member of the General Committee of Revision of the U. S. Pharmacopeia.

Dr. Glover's current term expires in 1995, and as an elected member, he automatically becomes chairman of the obstetric and gynecologic advisory panel for the U.S. Pharmacopeia Drug Information Division. This organization establishes the standards by which drugs are manufactured in the U.S.

The 128 members of the General Committee of Revision are elected from a national pool of scientists and physicians.

Murray appointed exam chair of ABTS

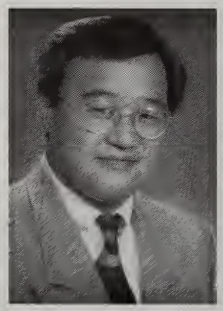
Murray

Dr. Gordon F. Murray, professor and chair of surgery, has been named examination chair of the American Board of Thoracic Surgeons (ABTS), the organization which certifies thoracic surgeons.

As examination chair, Dr. Murray is a member of the ABTS executive committee. He has served on the ABTS board of directors since 1988, and the thoracic examination subcommittee since 1989.

In addition to his new ABTS post, Dr. Murray recently was the Horace G. Smithy Visiting Professor in the Department of Surgery at the Medical University of South Carolina in Charleston, where he presented the lecture, "*Operative Management of Esophageal Motor Disorders.*"

Hand surgeon wins Bunnell Fellowship

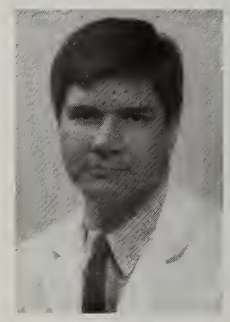

Ryu

Dr. Jaiyoung Ryu, an associate professor in the Department of Orthopedic Surgery, has been awarded the Sterling Bunnell Fellowship by the American Society for Surgery of the Hand.

This fellowship will enable Dr. Ryu to travel worldwide for three months to exchange ideas with the world's most prominent hand surgeons in 30 countries. It is awarded to just one surgeon a year.

Dr. Ryu performs hand surgery at Ruby Memorial Hospital and conducts and directs biomechanical research of the wrist and upper extremities.

Mansmann receives three special honors


Mansmann

Dr. Paris T. Mansmann, assistant professor of rheumatology and allergy/immunology, has been elected to a two-year term as co-chair of the Basic and Clinical Immunology Committee of the American College of Allergy and Immunology.

In addition, Dr. Mansmann has been nominated by the International Biographical Centre in Cambridge, England, as the 1994-95 "International Man of the Year," and he has just been listed in *"Who's Who in Medicine."*

Chief surgery resident elected to ORR board

Dr. David R. Jones, chief resident of general surgery, has been elected to the administrative board of the Organization of Resident Representatives (ORR).

West Virginia Chapter - American College of Surgeons

Annual Spring Meeting

May 4-6, 1995

The Greenbrier

White Sulphur Springs, WV

Guest Speakers include:

Alvin L. Watne, MD, FACS
Director, Cancer Center of Georgia, Atlanta, GA

- *"Breast Cancer, the More I Read, the More Confused I Get"*
- *"A Giant Step for Mankind"*

Harold Kleinert, MD, FACS
Clinical Professor of Surgery, University of Louisville, Louisville, KY

- *"Microsurgical Reconstructive Salvage Procedures"*
- *"Pain, Numbness, Tingling and Weakness in the Upper Extremities"*

For registration information, contact Sharon Bartholomew at (304) 598-2802.
For room reservations, contact *The Greenbrier* at (800) 624-6070.

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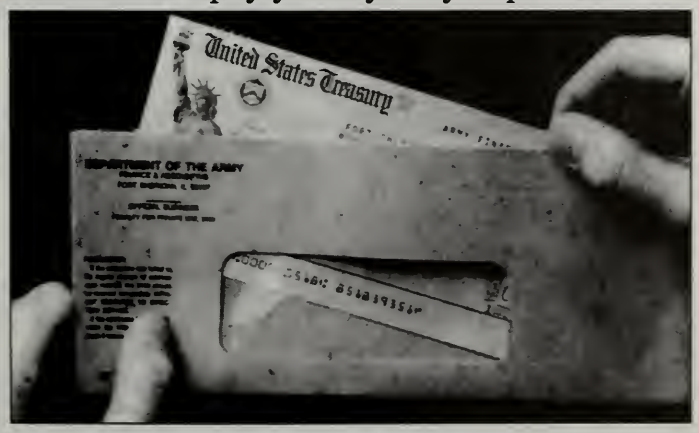

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NASA Advisory Board awards scholarships to 10 students

Student Suzanne Caynor, a three-time winner of a NASA Space Grant Scholarship, describes her research to Marshall President J. Wade Gilley. "My ultimate goal would include the pursuit of a Ph.D. in biomedical sciences and an opportunity to be a part of the advancement of the Human Genome Project," she said. ***(Photo by Rick Haye)***

Ten students preparing for careers in medicine, pharmacy and other sciences have received research scholarships through the Marshall University NASA Space Grant Advisory Board, according to Dr. Susan DeMesquita, professor of physiology.

One of the research recipients, Huntington freshman R. Christopher Harmon, is working with pharmacologist Monica Valentovic on the topic "*Modulation of Cephaloridine Nephrotoxicity.*" This antibiotic has been reported to produce renal damage, but has been shown to be less toxic in diabetic animals -- unless they had been pretreated with insulin. In his project, Harmon will investigate whether the insulin-treated diabetic rats have higher renal accumulations of cephaloridine than untreated diabetic rats.

The nine other student projects include mathematical research, a study of altered protein synthesis of brine shrimp in low-gravitational environments, and scanning tunneling microscopy studies of organic thin films on silicon wafers. This year's projects bring to 46 the number of NASA Space Grant Scholarships awarded by MU since 1992.

"In addition to the $9,500 NASA has given to the projects at Marshall, President Wade Gilley has provided more than $25,000 in matching and extra funds to bring the total to $35,430," Dr. DeMesquita said. "Stipends and supplies for this year's projects ranged from $700 to $1,000," she added.

In addition to Harmon, scholarship winners include Charles Priestley of Sumerco; Jennifer M. Jenkins of Kitts Hill, Ohio; and Suzanne Caynor, John Rahall, Marc A. Midkiff, Brett E. Harris, and Sam Lovejoy, all of Huntington.

Bloss Trust to create permanent endowment for Ob/Gyn Dept.

The Dr. James R. Bloss Trust, now totaling more than $500,000, has been transferred to the School of Medicine to establish a permanent endowment for the Department of Obstetrics and Gynecology.

The proceeds will be used to further the academic pursuits of students, residents and faculty in the department. Under this umbrella, funds can be made available for small or pilot research projects, special teaching programs, participation in national or international meetings, and similar activities.

"The Bloss endowment materially strengthens the foundation of the department and the medical school by increasing our self-sufficiency," said Dr. Robert C. Nerhood, professor and chairman of OB/GYN. "We are deeply indebted to Dr. Bloss for his foresight and generosity and to the trustees, Mrs. Edwin J. Humphrey Jr. and her son, Dr. Edwin J. Humphrey III, for their confidence."

Dr. Bloss and Dr. Edwin J. Humphrey Jr. were Huntington's pioneering OB/GYN physicians. Their partnership provided patient services as well as medical training for young doctors.

Dr. Wilkinson boosts funds for scholarship honoring his father

Dr. Walter R. Wilkinson, a retired Huntington surgeon, has contributed an additional $20,000 to a medical scholarship honoring his father, Dr. R. J. Wilkinson.

The elder Dr. Wilkinson was a preeminent figure in the Huntington medical community and the first surgeon and chief of staff at the city's former C & O Hospital. At the time he was appointed administrator of the hospital in 1915, he was one of the few formally credentialed surgeons in the area. Under his progressive administration, modern X-ray and laboratory facilities were installed and a nursing education program was created. "Dr. Bob," as he was known to thousands of patients in this community and throughout the C & O system, served the hospital with great distinction and national recognition until his death in 1953.

The West Virginia State Medical Association

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C	Deck 3,4 & 6(O)	$3120	$2295	$825
D	Deck 2(O)	$2880	$2120	$760
F	Deck 3&4 (I)	$2385	$1755	$630
G	Deck 2(I)	$2050	$1895	$155
H	Deck 2 & 4 (O)	$1675	$1395	$280

(O)=Outside Staterooms (I)=Inside Staterooms

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

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1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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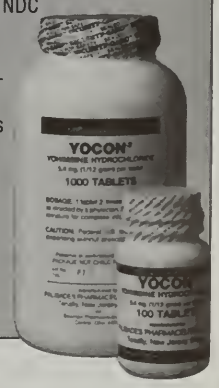

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An exceptional year

It has been an exciting and productive year for the WVSMA-MSS. During the past 12 months, I have been proud to see the MSS become a more vital and active component of the WVSMA and grow to total of 324 members. The WVSMA has welcomed our participation and we now have representation on several of the WVSMA's committees.

One of our accomplishments this past year was surveying all of the medical students in West Virginia. Our objective was to document their most important concerns about health system reform and rural medicine. The response to this survey has been outstanding and we plan to publish the results in the *Journal* later this year.

Another highlight for the MSS was our involvement at the annual AMA medical student meeting in Chicago last June. Seven students were able to attend this meeting, which was the largest delegation of medical students from West Virginia to ever attend an AMA annual meeting.

Our activities at the WVSMA's Annual Meeting at The Greenbrier in August were also very significant for the MSS during this past year. At this meeting, our resolution to create a Committee on Graduate Medical Education was passed by the members of the WVSMA's House of Delegates; and the board of WESPAC, the WVSMA's Political Action Committee, voted to include medical students as contributors. In addition, while this meeting was in progress I had the pleasure of visiting the West Virginia School of Osteopathic Medicine with WVSMA-MSS Vice President Nick Cottrell; WVSMA's Membership Coordinator Donna Webb; and AMA Account Representative Don Foy. As a result of this visit, we were able to recruit many very enthusiastic students and create a new MSS component society.

The final event for this year's MSS Executive Council will be our annual meeting on Saturday, January 21 at the Radisson Hotel in Huntington during the WVSMA\WV-ACP Mid-Winter Seminars and Scientific Conferences. A full day of activities is planned and registration will be held from 8 a.m. - 8:30 a.m. A special welcome from WVSMA representatives will begin at 8:30 a.m., and then at 9 a.m., Dr. Donald Weston, vice chancellor for health sciences, will discuss rural health care and how it affects our education and careers. Following Dr. Weston's presentation, Stephen Haid from the Perry and Haid Group, will deliver an update on the activities of the West Virginia Legislature. During lunch, Susan Griffith, the physician recruiter for Jackson General Hospital, will explain some of the issues of office management. After lunch, our business session will take place with final committee reports, resolutions to our bylaws, and nominations for next year's officers.

It has been both a pleasure and a privilege to have had the opportunity to represent the WVSMA-MSS. Thank you for your support and participation. I look forward to next year's Executive Council and another exceptional year.

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The West Virginia Tobacco Control Coalition is made up of 50 member organizations, including the American Lung Association of West Virginia, the American Cancer Society, West Virginia Division, Inc. and the American Heart Association of West Virginia.

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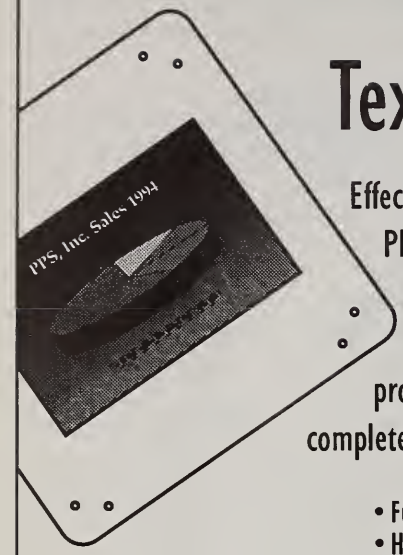

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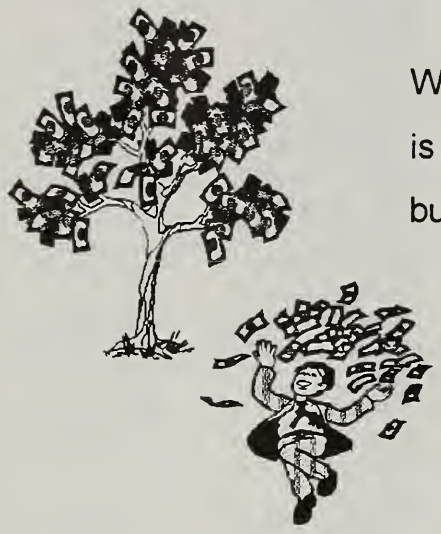

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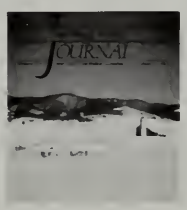

Front Cover

A picturesque scene of a farm near Hillsboro in Pocahontas County. Photo courtesy of *Gerald S. Ratliff,* West Virginia Division of Natural Resources.

What would make us stay in West Virginia?: Perspectives of the state's medical students

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Abstract

In summer 1994, a questionnaire was sent to all of the 822 allopathic and osteopathic medical students in West Virginia. They were asked if they planned to practice primary care in the state, and to rate the importance of financial, lifestyle, and educational factors that may impel them to practice in rural areas. The response rate was 51.8 %. The results indicated that 70.2% of the students were unsure about their career plans, but they were considering staying in the state as primary caregivers. Financial factors such as tuition waivers, loan repayment programs, the improvement of Medicaid and Medicare reimbursement, and the elimination of the 2% healthcare provider tax were the most important incentives that students stated would influence them to remain in the state. Responses also indicated that lifestyle factors such as the quality of schools for children and having backup may increase participation in rural care. Educational factors were not found to be important reasons affecting students' decisions to practice in rural areas, and many students stated they were unhappy with the current mandatory rotations in rural care. Out-of-state students displayed great interest in both staying in West Virginia and in becoming primary care physicians. Few differences were found between students depending on what school they attended or their gender.

Introduction

In a rural state such as West Virginia, many resources continue to be used to train and retain physicians for practice in rural areas. Too often, the utilization of these resources is determined by the guess work of medical educators or legislators. Rarely are the opinions of medical students considered in the overall process of attracting students into rural practice and, in West Virginia, many medical students have stated they are ignorant of the rural opportunities available.

As part of an ongoing research effort, the West Virginia State Medical Association's Medical Student Section (WVSMA-MSS) created a survey in order to obtain the opinions of the state's medical students regarding factors that would influence them to choose primary care and remain in the state to practice. The leaders of the WVSMA-MSS consider the responses to this survey a valuable resource for the state's educators and legislators to utilize when developing future policies concerning medical education.

Methods

In the summer of 1994, medical students from Marshall University, the West Virginia School of Osteopathic Medicine, and West Virginia University were sent questionnaires from the WVSMA-MSS with a self-addressed return envelope. All surveys were to be completed anonomously and returned by the fall of 1994.

Each survey contained 31 questions regarding financial, lifestyle, and educational factors that may influence students to stay in West Virginia, as well as locate in rural areas and choose primary care as their specialty. The students were asked to rate the factors using the following scale: 1 = strongly disagree; 2 = disagree; 3 = neutral; 4 = agree; and 5 = strongly agree. Each student was also asked to complete a section on demographics such as age, sex, marital status, state of residence prior to entrance into medical school, medical school of attendance, year of expected graduation, and plans to become a primary care physician. Primary care was defined as general internal medicine, family medicine, general pediatrics, and Ob/Gyn. In addition, space was provided for comments.

The results were placed in a spread sheet program where the mean of each factor was calculated. The factors were then separated into categories and ranked in order.

Results

Of the 822 surveys mailed to medical students, 426 were returned, which represented a 51.8% response rate. A total of 202 of the responses were from WVSOM students (47%), 132 of the questionnaires were from WVU students (31%), and 89 students responding attended MU (21%).

Demographic analysis of the responders revealed that the average age was 27; 57% were men; 56% had never been married; and 74% were residents of West Virginia before entering medical school. In addition, 142 students were in their first year of medical school, 92 were in their second year, 87 were in their third year, 71 were in their fourth year, and 26 were recent graduates.

Table 1. The Opinions of West Virginia's Medical Students Regarding Primary Care and Remaining in the State to Practice

All Students	Yes	Maybe	No
Do you plan to practice primary care?	230 (54.8%)	137 (32.6%)	53 (12.6%)
Are you planning to remain in WV?	152 (36.0%)	210 (49.8%)	60 (14.2%)
The number of students who are considering or would consider both of these options	109 (25.8%)	297 (70.2%)	17 (4.0%)

Table 2. Plans of West Virginia's Medical Students According to Class Year in School

Year in School	1st Year	2nd Year	3rd Year	4th Year	New Grad
I will stay in West Virginia	70 (49%)	32 (34.8%)	25 (28.7%)	14 (19.7%)	10 (38.5%)
I may stay in West Virginia	64 (44.8%)	46 (50.0%)	43 (49.4%)	42 (59.2%)	13 (50.0%)
I plan to leave West Virginia	9 (6.2%)	14 (15.2%)	19 (21.9%)	15 (21.1%)	2.9 (11.5%)
I will choose primary care	87 (60.8%)	50 (54.3%)	39 (44.8%)	41 (57.7%)	11 (42.3%)
I may choose primary care	50 (35.0%)	34 (37.0%)	38 (43.7%)	13 (18.3%)	2 (7.7%)
I will not choose primary care	6 (4.2%)	8 (8.7%)	10 (11.5%)	15 (21.0%)	13 (50.0%)
I will pursue both of these options	55 (38.5%)	22 (23.9%)	14 (16.1%)	13 (18.3%)	4 (15.4%)
I may pursue both of these options	87 (61.2%)	66 (71.7%)	66 (75.9%)	52 (73.2%)	22 (84.6%)
I will pursue neither of these options	0 (0.0%)	4 (4.3%)	7 (8.0%)	6 (8.5%)	0 (0.0%)
Total student's responses by class year	**142**	**92**	**87**	**71**	**26**

When students were asked if they planned to become primary care physicians and/or if they intended to stay in West Virginia, a significant majority stated they were planning (54.8%) or considering (32.6%) careers in primary care, with 36.0% stating they were planning or considering this option (49.8%) (Table 1). A significant number of students (25.8%) had plans to enter primary care and stay in West Virginia, but most students (70.2%) were undecided about this option. A few of the students (4.0%) had ruled out both primary care and remaining in the state.

The responses to the career plan questions are shown in Table 2, and it should be noted that only 26 of the new graduates responded. With a class of approximately 140, these responses may fail to be a true representation of the class of 1994. However, the 45%-90% response rate from the other classes is likely to be representative. This survey revealed a trend of fewer students planning to stay in West Virginia as they progressed in their education, but about one half of the students remained uncertain about deciding to stay in the state throughout their medical school education. Students appeared to be more decisive about primary care than staying in West Virginia. The number of students who simultaneously indicated that they plan to practice primary care and stay in the state steadily declined as graduation approached. A majority (70%-80%) of the students were considering staying in West Virginia and practicing primary care throughout their education.

The opinions of the students responding did not vary significantly according to what medical school they are or were attending. Overall, the differences between schools were small, but WVSOM students appear to be slightly more enthusiastic about primary care and staying in West Virginia than the students from the other two schools. In addition, WVU students did appear to be the most undecided about their career plans, followed by MU students and then the WVSOM students. Analysis by year of graduation showed that the fourth-year students at WVU had the strongest plans to stay in West Virginia, that the MU students had the strongest plans to pursue primary care, and that the fourth-year students at WVSOM had the most definite plans to both remain in the state and specialize in practice care.

A demographic analysis of the responses showed that career choices did not differ significantly between males and females. As a group, married students over the age of 30 were more inclined to stay in West Virginia. When comparing the answers relating to the career choices of the 347 students who grew up in the state with the 68 students who are legally residents of other states, it was interesting to note that the out-of-state students consistently demonstrated a greater interest in both primary care and staying in West Virginia.

Table 3 illustrates the students answers regarding the importance of different factors that would influence them to stay in West Virginia, locate in rural areas, and choose primary care. Of the three categories of factors investigated, financial factors were shown to be the most important to medical students. Tuition waivers and loan repayment programs appeared to be the most important financial incentives for students. As a group, the lifestyle factors were ranked second, and the most important lifestyle factor to be considered was having other physicians available to provide backup.

Educational factors were ranked lowest as a group by the students with a range of importance of only 3.85 to 3.50. The two most important educational factors they listed were having rural practitioners as preceptors and externships in rural communities. The students responding to the survey did not agree upon any one educational factor that would help entice them into rural care.

The survey contained two questions pertaining to the student's spouses. Responses from the married medical students revealed that they felt that career and educational opportunities for their spouses were more important than whether a spouse grew up in a rural area (4.37 versus 3.84 respectively).

Besides just answering the questions listed on the survey, a total of 138 students (32.4%) shared additional comments, which were usually at least a paragraph in length. Many students provided negative comments concerning the 2% health provider tax, and some students cited this tax as an example of why they plan to leave the state.

Students also expressed concern that many of the reforms taking place in medical education in West Virginia as a result of the Kellogg and rural initiative program have adversely affected medical school curriculums. Many students indicated that they fear they will lose the freedom to choose what area of medicine they will enter, and some students were dissatisfied with the decision to require a mandatory rotation of two consecutive months in rural care.

The comments further revealed that medical students prefer incentives, not mandates, to entice them to remain in the state after graduation and practice primary care. However, their comments were also dominated by concerns over debts incurred during medical school

Table 3. Factors That Would Influence West Virginia's Medical Students To Practice Primary Care In The State

Financial Factors	Mean
Tuition waivers	4.53
Loan repayment programs	4.52
Improved Medicaid and Medicare reimbursement	4.47
Salary guarantees	4.45
Reimbursement for start up costs	4.39
Stipends from rural hospitals	4.38
Improved financial aid and loan database	4.27
Abolishing the 2% health care provider tax	4.22
Reimbursement for moving expenses	4.21
Malpractice climate	3.98
Book stipend	3.80
	mean = 4.29
Lifestyle Factors	
Improved backup for out-of-town vacations	4.54
Quality schools for children	4.48
Being located near a community hospital	4.38
Opportunities for spouse employment/education	4.37
Improved backup for out-of-town training	4.36
Flexibility in practice content	4.29
Availability of new diagnostic equipment	4.29
Contact with tertiary care center	4.18
Recreational facilities	4.13
Cultural opportunities	4.09
Spouse growing up in a rural area	3.84
	mean = 4.27
Educational Factors	
Rural practitioners as preceptors	3.85
Externships in rural communities	3.83
Exposure to rural practice in medical school	3.79
Exposure to rural practice in residency	3.76
CME opportunities in rural setting	3.59
Rural practitioners as lecturers	3.50
	mean = 3.72

and how these debts negatively influenced their decision to embark on a primary care career in rural West Virginia. Solutions offered to this dilemma included a curbing of medical school costs. In addition, many students expressed an intense desire for tort reform, and indicated a willingness to stay in the state if limits were set upon the amount of money that could be awarded in malpractice suits.

Discussion

The medical educators in West Virginia are succeeding in their efforts to produce more primary care physicians. This is evident by the fact that MU was ranked second highest in the U.S.in 1993 in the percentage of graduates entering family practice residencies (1), and was recently rated second highest in the U.S. in the percentage of graduates entering primary care practices (2); as well as the fact that in 1994, WVU had its highest number of students ever choosing primary care residencies (3).

These statistics are especially compelling when you take into consideration the fact that nationally studies have shown that students lose interest in primary care as they progress through medical school (4). However, the WVSMA-MSS survey indicates that interest in primary care appears to remain constant with West Virginia's medical students as they advance through school. In fact, the WVSMA-MSS survey demonstrates that 75%-80% of the state's medical students are considering primary care at any given time in their education. This represents an excellent opportunity for medical schools to recruit primary care physicians for underserved areas of West Virginia.

The rural health care initiative programs have focused their recruitment efforts upon senior students and recent graduates. However, the survey revealed it was the freshman and sophomore medical students displayed the greatest interest in staying in West Virginia. In addition, the desire to remain in West Virginia to practice appeared to decline as students went through school. As a result, legislators may wish to discuss offering tuition waivers and stipends to future rural primary care physicians during their first and second years of medical school when their interest in staying in West Virginia is the strongest. This early recruitment approach has been utilized by the armed services to attract medical students for many years.

Another significant point brought out by the survey was the realization that financial debt has a very influential impact upon student's career choices. It has been shown that students become less willing to enter primary care when their debt surpasses $50,000 (5). It is interesting to note that this debt threshold is surpassed by many medical students in West Virginia as they enter their junior and senior years of medical education. As a result, many students may be selecting careers outside of West Virginia in an effort to pay back their student loans. The students in our survey indicated that they felt ignorant about the financial aid and loan repayment programs currently in place, so it is obvious that educators should place more emphasis upon the awareness of such programs.

Surprisingly, out-of-state students demonstrated a strong interest in staying in West Virginia and in practicing primary care. It appears that having more out-of-state students may be a viable option for educators who are interested in recruiting rural practitioners. Decreasing the financial burdens of out-of-state students may further increase the supply of rural physicians in West Virginia.

A previous survey of young physicians in West Virginia conducted by Dr. James Helsley, an assistant professor of family medicine at WVU who is president-elect of the WVSMA, and Dr. Marian Swinker, a former professor of family medicine at WVU, found that greater reimbursement for family physician services was one of the most important factors that would encourage participation in rural care (6).

The students in our survey also agreed that reimbursement was an important factor. Legislators may wish to include improved reimbursement from Medicare and Medicaid in any health care reform plans, as well as eliminate the 2% health care provider tax to keep medical students from leaving the state.

The study by Helsley and Swinker also indicated that the presence of other family physicians was among the most important enticements for young physicians to locate in a rural area. The results of our student survey support this finding that having back up available is a very important factor. It appears that both students and young physicians fear becoming responsible for taking call 24 hours a day, 365 days a year for the duration of their professional life. It becomes obvious that as more students enter rural primary care, a support network should be established which would allow rural physicians the ability to leave town or have time off.

The young physicians surveyed by Helsley and Swinker ranked their spouses' needs as being only marginally important, while the students in the WVSMA-MSS survey placed a greater value upon the needs of their spouses. In fact, married students indicated that they felt that educational and employment opportunities for their spouses were very important.

Students in the WVSMA-MSS survey stated that the educational factors to be among the weakest enticements to interest them in entering primary care. Having rural practitioners as preceptors and offering externships in rural communities ranked the highest of all the educational factors. However, it should be emphasized that the students failed to agree that these measures would influence their decision to enter primary care. Some authorities claim that increasing exposure to rural primary care may increase students' interest and participation (7). Yet, the students surveyed viewed mandatory participation in rural rotations as another attempt to limit their freedom of choice.

One important area which was not covered in the WVSMA-MSS survey concerns the negative perceptions many people have about West Virginia. Poverty and isolation are often associated with West Virginia; images which have somehow been ingrained into our society and continue to be propagated, especially by the media.

Why is it that the media is not portraying West Virginia in a better light? West Virginia's leaders must do much more to increase tourism and promote all of the positive aspects of *"Almost Heaven, West Virginia."* These efforts will, in the long run, help to encourage more out-of-state students, as well as give the in-state students more pride and increase the likelihood of them remaining in West Virginia to practice. Interestingly, the pros and cons of rural practice were recently explored in an article in the *West Virginia Medical Journal* by Dr. Gregory Juckett, who was a rural practitioner in West Virginia before joining the WVU faculty in Morgantown (8).

Conclusion

The West Virginia medical education system appears to be having great success in producing students interested in becoming primary care physicians. The system must now focus upon the retention of these physicians.

Although 25.8% of the students surveyed plan to practice primary care in West Virginia, 70.2% remain undecided. This may represent an opportunity for educators and legislators to increase the number of medical students who remain the state to practice primary care. It appears that the most promising way to achieve this goal is by offering loan repayment programs, and possibly stipends. Increasing student awareness of current financial and reimbursement opportunities may also be helpful, as well as educating students about the positive lifestyles available in a rural West Virginia practice.

It remains difficult to ascertain the motivating factors behind the trends reported in this survey. The leaders of the WVSMA-MSS have decided it will be beneficial to continue this survey on a yearly basis to distinguish such factors as whether students are becoming less interested in staying in West Virginia as they go through school, or are new admission policies impacting each new group of students? These questions may need to be addressed to further validate conclusions.

This survey was intended to serve as a guide to how the medical students of West Virginia rate different factors involved with rural care. Many of the factors investigated are beyond any legislative or educational control, but several of these factors are controllable. It is hoped that legislators and health educators will consider the opinions of these future physicians as they develop policies concerning medical education and health care.

Acknowledgements

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Continued benefit of lovastatin in the treatment of hypercholesterolemia in 36 patients

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Abstract

After one year of treatment, low-dose (20 mg/d) lovastatin achieved continued efficacy without tachyphylaxis in 36 patients with Type II_a or II_b hyperlipoproteinemia. Six week and one year reductions in low density lipoprotein (LDL) cholesterol were significant at 33% and 31% in these patients respectively; reductions in total cholesterol were also significant at 25% and 22% respectively. Increases in high density lipoprotein cholesterol (HDL) were 6% at six weeks and 10% at one year; triglycerides were reduced 16% and 11% respectively. The cholesterol lowering effects were similar for males and females (23% and 21% respectively). Low-dose lovastatin (20 mg/d) is a good choice for reducing cholesterol in patients with primary Type II_a or II_b hyperlipoproteinemia refractory to diet therapy because it is effective in lowering LDL-cholesterol, while raising HDL-cholesterol with few side effects and without tachyphylaxis.

Introduction

In 1985, the NIH Consensus Panel reported on the effects of high blood cholesterol levels in man, demonstrating the strong relationship between high blood cholesterol and the development of coronary artery disease. They stated that those patients with moderate to high cholesterol levels would significantly reduce their risk of coronary artery disease by lowering their blood cholesterol.

Diet therapy was the recommended treatment, with drug therapy the next step if diet therapy was unsuccessful. One of the goals set by this panel was to reduce the blood cholesterol levels of the entire adult population to below 5.17 mmol/L (200 mg/dL) (1), since previous studies had shown a significantly lowered coronary artery disease risk in those individuals who were able to lower their blood cholesterol with cholestyramine, a bile acid sequestrant (2,3).

Bile acid sequestrants and other cholesterol-lowering drugs often have many unwanted side effects which patients cannot tolerate (4). However, one of the newer prescriptions for lowering cholesterol, the 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors, do have fewer side effects than earlier pharmacological agents (5). These agents work by competitively inhibiting de-novo cholesterol synthesis (6,7).

The first available agent was lovastatin, which in short-term studies has been effective in lowering total cholesterol with very few adverse effects (8,9,10). Unfortunately, since lovastatin has only been on the market since 1987, there have been very few studies comparing it with a placebo. However, the one year-long study that did compare lovastatin to placebo (11), did show lovastatin to have encouraging results in lowering cholesterol with few side effects.

The recommended starting dose of 20 mg with the evening meal was employed in an earlier study which followed patients for 24 weeks (9). The study we conducted is an extension of that research and followed patients for over one year to assess lovastin's longer-term effectiveness and side effect profile.

Subjects and methods

Patients included in this study were individuals between the ages of 25-85 years who had Type II_a or II_b primary hyperlipoproteinemia, in whom the serum total cholesterol did not fall below 200 mg/dL with diet therapy. All patients had evidence of coronary artery disease (defined by having either a positive stress test with angina, history of myocardial infarction, or documented coronary artery disease by catheterization). Only patients receiving lovastatin as the sole pharmacological agent to treat their hypercholesterolemia were included.

Excluded from the study were patients with renal dysfunction, history of alcohol abuse, uncontrolled hypothyroidism, liver disease, diabetes milletus, or a coronary artery bypass in the three months previous to the start of the study. Patients were also excluded from this study if their homozygous familial hypercholesterolemia was defined by cholesterol levels greater than 10.35 mmol/L (400 mg/dL) and tendon xanthomas.

Patients in the study were chosen from a population that presented for cardiac evaluation. At that time, initial cholesterol levels were measured with the patients in a fasting state for at least 12 hours. Those with a fasting cholesterol level above 6.21 mmol/L (240 mg/dL) were put on a 12-week diet consisting of less than 200 mg/dL of cholesterol with less than 8% of total calories from saturated fat. At the end of this 12-week period, those with fasting total cholesterol levels about 5.17 mmol/L (200 mg/dL) were placed of lovastatin due to their failure to respond to diet therapy as a means to lower their serum cholesterol levels, and they were maintained on the same low cholesterol diet. Compliance to this diet was evaluated through patient interviews and measurement of body weight, before lovastatin was prescribed.

Lipid levels were also measured prior to the initiation of diet therapy, and every six weeks after that for one year. Each patient was his or her own control based on initial cholesterol measurements. Lovastatin was started 12 weeks after original assessment for those patients who failed to respond to the diet therapy previously described. Each of these patients took 20 mgs of lovastatin once daily with their

evening meal. The modified Lipid Research Clinics heparin-manganese chloride procedure was utilized for high-density lipoprotein (HDL) levels. The low density lipoprotein (LDL) levels were calculated with the formula: LDL = total cholesterol - HDL cholesterol - (triglycerides/5). The paired t-test was used to compare pretreatment levels and levels at one year for significance.

At the initiation of lovastatin therapy, baseline readings were performed by conducting liver function tests (serum alanine aminotransferase, gamma-glutamly-transferase, aspartate aminotransferase, and total bilirubin), creatinine phosphokinase level measurements, and eye examinations to evaluate the presence of lens opacities. The liver function tests were repeated every six weeks during the lovastatin treatment.

In order to determine which patients had the most effective response to lovastatin therapy, the data was divided into categories depending on age, gender, and entry cholesterol value. Differences in these categories were then evaluated using the paired t-test. Since it was previously discovered that the maximal therapeutic effect of lovastatin is reached within six weeks (9), the values compared were the initial values, the six-week values and the one-year values.

Results

Sixty-four patients started the prescribed lovastatin regimen, but the dosage had to be increased n 24 of these patients due to a less than desired reduction in cholesterol with the initial 20 mg dose. Three other patients were dropped from the study due to non-compliance. Only one patient was dropped due to a possible side effect -- this patient developed a petechial rash on her lower legs and blamed the lovastatin even though she was taking multiple medications and her physician did not think that the lovastatin caused the rash.

Thirty-six patients were followed on the 20 mg daily regimen for one year. The mean age of these patients was 63 years (44% male and 55% female). At the initiation of lovastatin therapy, the mean total cholesterol level was 6.96 mmol/L (269 mg/dL) with a range of 6.47 mmol/L to 9.62 mmol/L (204 mg/dL to 372 mg/dL). By 6-7 weeks after initiation of therapy, cholesterol levels had fallen an average of 25% to 5.25 mmol/L (203 mg/dL) with a range of 3.86 mmol/L to 6.37 mmol/L (149 mg/dL to 246 mg/dL). Mean HDL cholesterol rose 6% from 1.29 mmol/L (50 mg/dL) to 1.37 mmol/L (53 mg/dL) by this time. Mean LDL levels fell 33% from an initial value of 4.55 mmol/L (176 mg/dL) to 3.05 mmol/L (118 mg/dL). In addition, triglycerides fell 16% from 4.87 mmol/L (188 mg/dL) initially to 4.09 mmol/L (158 mg/dL).

These six-week values were very similar to the measurements taken at one year after the initiation of lovastatin therapy (mean = 53 weeks, with a range of 42-63 weeks). These values at one year's time were compared to the initial values statistically for significance. The total cholesterol level remained 22% lower than the initial values at 5.43 mmol/L (210 mg/dL) with a range of 4.30 mmol/L to 7.19 mmol/L (166 mg/dL to 278 mg/dL). This is statistically significant with p = <.001.

HDL cholesterol was reduced at one year by 10%. Actual measurement was 1.42 mmol/L (55 mg/dL) with a range from 0.70 mmol/L to 2.28 mmol/L (27 mg/dL to 88 mg/dL). This difference was not statistically significant (p = 0.370).

LDL cholesterol was 31% lower than initial values at 3.16 mmol/L (122 mg/dL) with a range of 1.45 mmol/L to 5.02 mmol/L (56 mg/dL to 194 mg/dL). This was statistically significant at p = <.001.

Triglycerides stayed 11% lower than initial levels at 4.32 mmol/L (167 mg/dL) with values ranging from 1.27 mmol/L to 9l.01 mmol/L (49 mg/dL to 348 mg/dL). However, this reduction was not statistically significant (p = 0.174) (Figure 1).

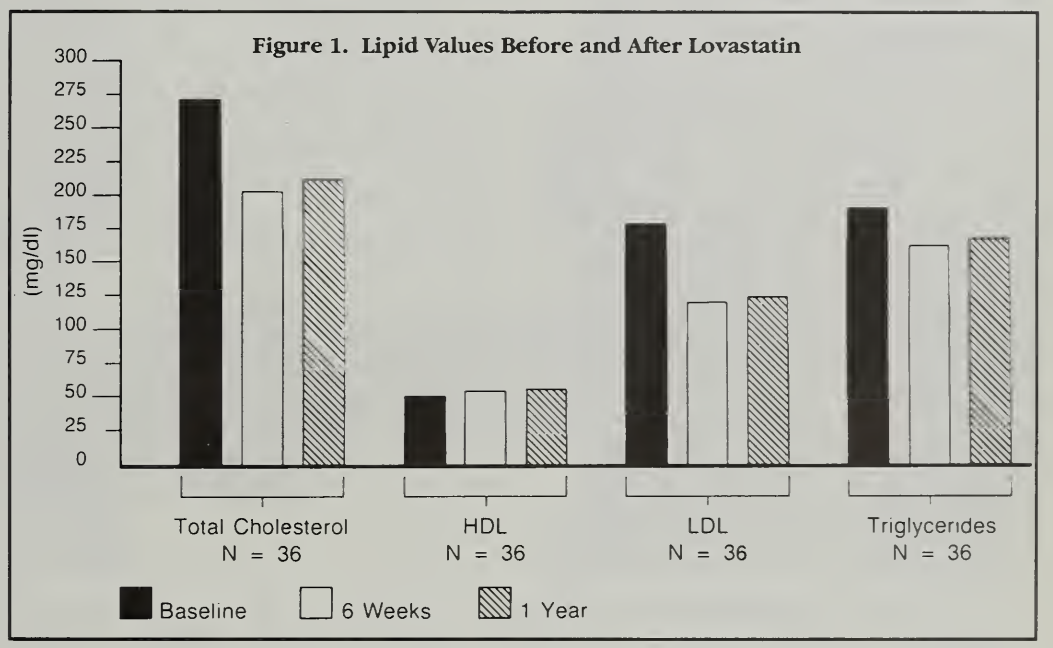

Figure 1. Lipid Values Before and After Lovastatin

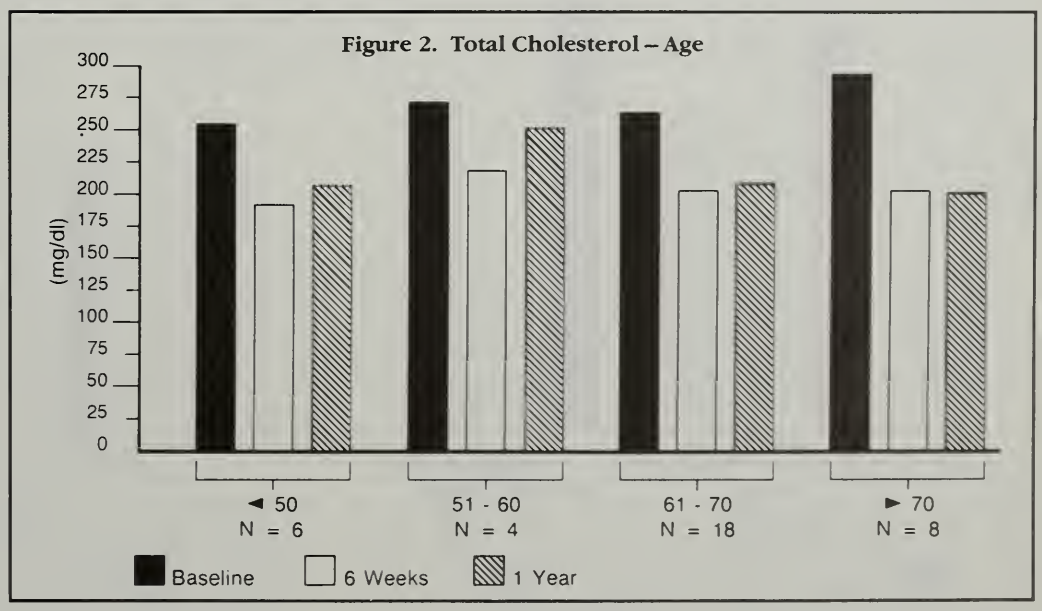

Figure 2. Total Cholesterol – Age

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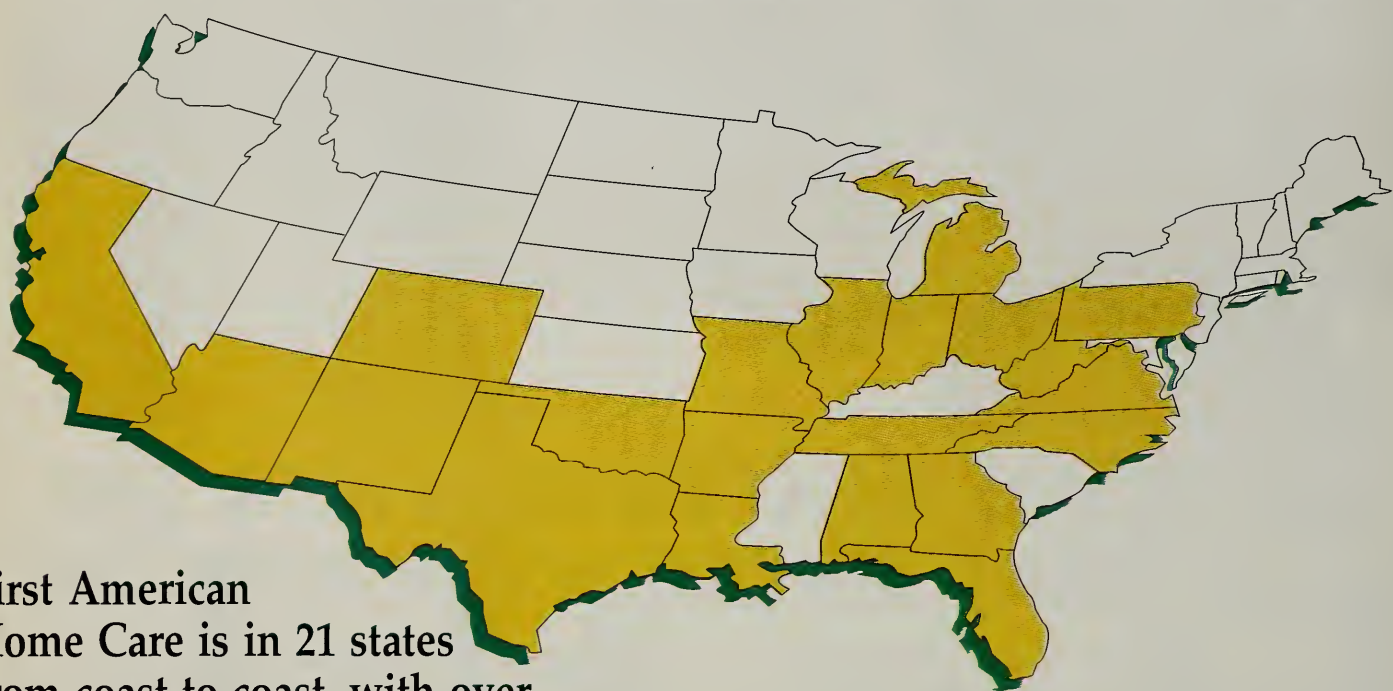

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sexes equally benefited from the use of lovastatin. Older patients (> 70) and those with high initial values (> 7.76 mmol/L (300 mg/dL)) had the greatest benefit.

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West Virginia Chapter - American College of Surgeons

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- *"A Giant Step for Mankind"*

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Clinical Professor of Surgery, University of Louisville, Louisville, KY

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The management of menopausal symptoms in women with breast cancer

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Abstract

The symptomatic postmenopausal woman with breast cancer presents the clinician with a difficult task with respect to hormone replacement therapy (HRT). All of the published meta-analyses have been consistent in showing that there is a slightly increased risk of developing breast cancer in those patients using postmenopausal estrogens for greater than 10 years. However, there have been no published placebo-controlled clinical trials on the effects of HRT in women with a history of breast cancer. Quality of life must be balanced against the theoretical risk of tumor promotion. Assessment of osteoporotic and cardiac risk factors (i.e., smoking, hypertension, family history, hyperlipidemia) should influence the decision. Valid alternatives to estrogen replacement include low-dose progesterones such as Bellergal or vitamin E for hot flashes, and biphosphonates, calcium, anabolic steroids, and calcitonin for osteoporosis.

Introduction

Long-term hormone replacement therapy (HRT) for estrogen-deficient women is associated with a reduced risk of osteoporotic fractures and coronary artery disease (Table 1). However, the use of postmenopausal low-dose estrogens in women with a history of breast cancer is controversial because many physicians fear the use of estrogens in these patients will stimulate their cancer.

As a result of not being treated with estrogen therapy, many of these women will suffer intolerable hot flashes, vaginal dryness, bladder symptoms, myalgias, and mood swings. They may also survive the cancer only to suffer an osteoporotic hip, vertebral fracture or premature myocardial infarction due to estrogen deficiency. In addition, the chemotherapy used to treat breast cancer can often induce premature menopause in younger women and these individuals are at a particular risk of the sequelae of estrogen deficiency.

This article reviews the literature on the subject of estrogen therapy and breast cancer, and describes alternatives to estrogen replacement.

Literature review

At least 39 epidemiological studies of estrogen therapy and breast cancer have been published since 1970 (1), and the findings of these studies are not consistent. Among the original articles, risk estimates ranged from a protective to an adverse effect in women who never used estrogens; no consistent quantitative effects of estrogens on breast cancer risk were found.

To help resolve the apparent conflict in the literature, the techniques of meta-analysis have been applied to this controversy. Five meta-analyses (2-6) published recently have attempted to determine the direction and overall magnitude of the effect of estrogen use on breast cancer risk, as well as to identify quantitative differences in dose and duration of estrogen use on breast cancer risk.

These published meta-analyses were all consistent in showing that the relative risk of developing breast cancer is about 1:1 after 10 years and that it is unlikely to exceed 1:3. No strong conclusions could be drawn regarding the effect of dose or of the particular type of estrogen used, although there was evidence that the risk increases with the duration of treatment. In addition, these meta-analyses also did not provide much information available to assess the role of co-treatment with progesterones, or provide data on the safety and efficacy of estrogen replacement therapy for women who have had breast cancer.

What is the practicing physician to make of all this data? While retaining a degree of caution about the power of meta-analysis to verify relative risks below 2, one may conclude that for a woman of about 50 years of age, a 10 percent increase in relative risk translates into an increase in the absolute risk of developing breast cancer from 9 percent to 10 percent during the remainder of her life. This risk may be higher in women with a first-degree relative with breast cancer or with atypical hyper-plasia.

Although additional observational studies may provide better estimates

Table 1. Benefits and Risks of Estrogen Replacement Therapy

	Benefits	
	Magnitude of Risk Reduction	
Condition	**Estrogen**	**Estrogen + Progestin**
osteoporotic fractures	25% for hip fracture; 50% for vertebral fracture	data insufficient
coronary artery disease	35%	data insufficient; may protect
	Risks	
	Magnitude of risk	
endometrial cancer	increased 8-fold	not increased
breast cancer	probably no higher than general population if exposure < 5 years	data insufficient
	May rise slightly (30%) after 10 years	25%-30% increase in risk after 10 years

of the association between estrogen use and breast cancer risk, only a randomized clinical trial can address a causal relationship. The National Institutes of Health (NIH) is currently sponsoring a large interventional study called the Women's Health Initiative to assess the overlapping effects of HRT, low dietary fat, and calcium/vitamin D supplements on coronary heart disease, osteoporosis, and cancer in healthy postmenopausal women, which presents a unique opportunity to resolve the estrogen/breast cancer controversy in a prospective clinical trial (7,8).

In another study presently underway, investigators at M.D. Anderson Hospital have started a randomized clinical trial of estrogen replacement therapy in women with prior breast cancer. In addition, the Eastern Cooperative Oncology Group (ECOG) has proposed a study of estrogen replacement therapy (Premarin .625 mg. p.o.) versus placebo in postmenopausal women with a history of breast cancer who are receiving adjuvant tamoxifen.

Managing menopause without estrogen

An approach to the menopausal patient with breast cancer is shown in Table 2. Before considering estrogen therapy in these individuals, physicians should assess the woman's risk factors for heart disease (e.g., family history, smoking, hypertension, lipid profile), osteoporosis (e.g., family history, diet, drug or alcohol history, bone mineral density), and subsequent breast cancer (e.g., benign breast disease, family history, size of tumor, axillary node status, etc.). Many alternatives to estrogens are available to counteract the consequences of estrogen deprivation, although none of these other options have been proven to be as beneficial as estrogen itself (9).

Hot flashes (9) may be reduced by progesterones (Megace 20 mg b.i.d.), anticholinergic medications (e.g., Bellergal-S one capsule twice daily), Clonidine (either 0.1 mg twice daily orally or 0.1 or 0.2 mg weekly via a patch), androgens (e.g., Danazol 100 mg daily), antidopaminergic agents (e.g., veralipride 100 mg per day or metoclopramide 40 mg daily), and vitamin E (400-800 p.o. daily). Vaginal dryness or dyspareunia may be managed with water-soluble lubricating agents (e.g., Replens). Estrogen creams should be avoided as they are significantly absorbed from the vagina. In additon, the non-estrogenic drugs reported to counter the development of osteoporosis include calcium/vitamin D, non-estrogen steroid hormones (e.g., progesterones, androgens), biphosphonates (e.g., Didronel), calcitonin, and sodium fluoride.

Tamoxifen is commonly prescribed as adjuvant therapy for breast cancer and does have some beneficial effects on menopausal pathophysiology. Its action may induce estrogenic activity on the vagina, uterus, liver, and bone (10). Thus, women with breast cancer receiving tamoxifen may have a slightly increased risk of endometrial cancer and may have a well-estrogenized vagina.

The impact of tamoxifen on lipids is modest (e.g., slight decrease in serum cholesterol and triglycerides), but recent evidence suggests that it may inhibit bone loss associated with menopause (10). On the basis of this information, one could use tamoxifen as an alternative to estrogen in women with breast cancer. Unfortunately, tamoxifen may aggravate hot flashes and cause troublesome vaginal discharge.

The patient with early stage breast cancer who has failed to control her menopausal symptoms with the therapies previously described will have to weigh the theoretical risks of HRT against the improvement in her quality of life. If she decides to take HRT, the minimum dose required to alleviate symptoms (e.g., Premarin 0.625 mg. daily) should be used. In view of the lack of placebo-controlled clinical trials on the effects of HRT in women with a history of breast cancer, it may be prudent to obtain written patient consent before initiating treatment.

When all else fails and the quality of life is poor, HRT should be considered. A patient dying with end-stage disease should not have to suffer menopausal symptoms as well.

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Table 2. An Approach to the Menopausal Patient With a History of Breast Cancer

ASSESS RISK FACTORS

Cardiovascular
Family history, smoking, exercise, blood pressure, lipid profile

Osteoporosis
Family history, diet, past history, drug history, bone densitometry

Breast cancer details
Histopathology; i.e., well/poorly differentiated, or S-phase; size of tumor; axillary node status; estrogen receptor status, type of therapy; time elapsed since prior diagnosis

HOW DISRUPTIVE ARE MENOPAUSAL SYMPTOMS? CAN ALTERNATIVES TO HORMONE-REPLACEMENT THERAPY BE USED?

Hot flashes
Can try progesterones, Bellergal S (1 b.i.d.), Clonidine patch (0.1 or 0.2 mg. weekly), Reglan (10-40 mg/day), vitamin E (400-800 mg. after dinner)

Vaginitis
Can try water-soluble lubricating agents; (e.g., Replens)

Osteoporosis
Anabolic steroids, biphosphonates, calcium/ vitamin D, calcitonin

Tamoxifen
May preserve bone mineral density and has favorable effect on lipids and coronary disease

IF THERE IS NO ALTERNATIVE AND SYMPTOMS ARE SEVERE

With informed consent, use estrogen (e.g., Premarin 0.625 mg/day) +/- progesterones or participate in the several clinical trials comparing conjugated estrogens versus placebo.

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Successful case of extracorporeal life support in a patient with postcardiotomy cardiogenic shock

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RONALD C. HILL, M.D.
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Abstract

Over the past five years, the use of extracorporeal life support in the adult population has gained acceptance. Indications have ranged from respiratory failure secondary to trauma, and adult respiratory distress syndrome, to cardiac failure secondary to a number of causes. The results of extracorporeal life support, when applied to postcardiotomy patients, have been variable. In this article, we present the successful utilization of extracorporeal life support for 28 hours in a patient with postcardiotomy cardiogenic shock following mitral valve replacement.

Introduction

Extracorporeal membrane oxygenation (ECMO) has been very helpful in the management of the neonatal patient with respiratory distress, but the results have been extremely poor when this type of intervention was directed toward the adult population. However, recently technological improvements have enabled the application of ECMO to adult problems, and its scope has been broadened to include cardiac support as well. For this reason, Barrett has coined the term "extracorporeal life support" (ECLS) to offer a more accurate description of the procedure (1).

This article describes our successful use of ECLS in an adult patient with postcardiotomy cardiogenic shock.

Case presentation

A 58-year-old white female was admitted electively for mitral valve replacement. Her past medical history was significant for asthma and rheumatic heart disease. She had remained relatively asymptomatic for eight years following a mitral commissurotomy.

Five months prior to admission, this patient had developed symptoms of worsening congestive heart failure, and a cardiac catheterization performed one month prior to admission demonstrated a cardiac output of 3.7 L/min, a cardiac index of 2.3 L/min/M^2, and a transmitral gradient of 8 mmHg. Pulmonary artery systolic pressures were 60-80 mmHg and left ventricular ejection fraction appeared significantly decreased. In addition to the mitral stenosis, there was three plus mitral insufficiency.

Physical examination was significant for a 4/6 systolic murmur, a diastolic murmur, and rhonchi bilaterally. The patient had clubbing of the digits and slight pitting edema of the lower extremities. Routine preoperative laboratory values were within normal limits with the exception of a serum creatinine of 1.5.

The patient was taken to operating room where the mitral valve was observed to have a retracted posterior leaflet and a very diseased anterior leaflet, making repair extremely difficult. As a result, we replaced the valve with a number 31 St. Jude prosthesis. The pump time was 195 minutes with a cross clamp time of 99 minutes. In weaning from bypass and with maximal inotropic support, plus the intraaortic balloon pump, the cardiac index was only 2.0 L/min/M^2. Efforts to close the chest ominously decreased the cardiac index to 1.3 L/min/M^2. For this reason, the chest was closed with an Esmark patch (Baxter Hospital Supply, Warrendale, Pa.)

Postoperatively, this patient developed a coagulopathy and, despite support with blood products and pharmacologic agents, tamponaded approximately 12 hours later. Her chest was opened in the intensive care unit and open cardiac massage was performed. Immediately, she was returned to the operating room and placed on bypass using the Carmeda Bioactive Surface System (CBAS, Carmeda Medtronic Inc., Stockholm, Sweden), but because cardiovascular function did not improve, the bypass was converted to ECLS.

Conduct of ECLS

The patient's ECLS was maintained by way of central cannulation using the aorta and right atrium. The activated clotting time (ACT) was 240 seconds prior to initiation of bypass. Blood flows were determined by venous saturations and hemodynamic support needs and were easily maintained between 3.0 and 4.2 liters per minute. Systemic heparinization was discontinued approximately six hours after the initiation of bypass and ACT returned to normal values during the remainder of ECLS. The patient remained normothermic throughout the entire course.

During ECLS, the patient required 30 units of packed red blood cells, 16 units of fresh frozen plasma, 40 units of platelets and 30 units of cryoprecipitate. She was taken to the operating room 28 hours after the initiation of ECLS and weaned from support. Seven days following her initial operation the chest was closed, and 48 hours later the intra-aortic balloon was removed. Unfortunately, 10 days later she developed acalculous cholecytitis requiring cholecystectomy. However, despite further complications of pancreatitis requiring total parental nutrition and a tracheostomy, she was weaned from the ventilator and discharged home on postoperative day 62.

Discussion

Although a proven modality in the neonate, extracorporeal membrane oxygenation (ECMO) had been largely abandoned for use in the adult patient by 1980 secondary to a mortality rate of 90%. Fortunately, increasingly improved results with cardiopulmonary assist devices related to enhanced patient selection and technologic advancements have been obtained since the start of this decade (2,3). Along with this progress has come a delineation of terms with extra corporeal life support (ECLS) being used to refer to simultaneous cardiac and pulmonary support rather than ECMO which refers only to pulmonary support (1).

The indications for ECLS are becoming increasingly broad, ranging from adult respiratory distress syndrome to a multitude of etiologies including pulmonary contusion from trauma, status asthmaticus and overdose. Additionally, ECLS has been used as a means to support primary cardiac failure due to myocardial

infarction, postcardiotomy cardiogenic shock, as well as a bridge to heart or lung transplantation (4).

Our utilization of ECLS in this patient experiencing postcardiotomy cardiogenic shock has been one of the least successful indications for ECLS reported in the literature (4,5). In 1991, the covalently-bonded, heparin-coated, bypass system, Carmeda Bioactive Surface (CBAS), was introduced by Larm and associates (6). This system, which demonstrates excellent biocompatibility, has had a great impact in the advancement of ECLS by decreasing bleeding complications (7).

Magovern has reported a group survival rate of 57% (52% to discharge) when he utilized ECLS to treat a series of 21 patients for postcardiotomy cardiogenic shock. These 21 patients were categorized according to the indication for their cardiotomy, and those individuals who had undergone postcoronary artery bypass grafting had an 80% survival rate, whereas the patients that had a mitral valve procedure performed or CABG following cardiac arrest had a 0% survival rate (8). The poor outcome in the patients who had undergone a mitral valve operation was felt to be due to increasing left ventricular distention from poor left-sided decompression with only right atrial cannulation.

In the patient we treated, we used right atrial and aortic arch cannulation sites only. The requirements of 30 units of packed red blood cells, 16 units of fresh frozen plasma, 40 units of platelets and 30 units of cryoprecipitate attests to the ongoing fibrinolysis and coagulopathy during cardiotomy compounded in our patient by the open chest cannulation and IABP. The volume of blood products is comparable to that reported by Magovern (40 +/- 8.7 units of PRBC, 26.3 +/- 14.5 units FFP, and 58 +/- 32.5 units of platelets) for patients status after mitral valve operations (8).

The complications encountered in our patient following the ECLS course (pancreatitis, gangrenous gallbladder, difficulty in weaning from respirator) do not appear to be temporally related to the ECLS course, but certainly cannot be excluded. In addition, our patient showed no sign of adult respiratory distress syndrome during her hospitalization, which has been a reported sequelae of ECLS.

Conclusion

Cardiac support by ECLS using the CBAS system is a viable option for postcardiotomy cardiogenic shock. We were successful in utilizing this system on a patient with postcardiotomy cardiogenic shock following mitral valve replacement.

Acknowledgement

The authors would like to thank Erin Foley-Weller, CCP, and Paul Arsenault, CCP, for their perfusion expertise in caring for our patient. They would also like to extend their appreciation to Balinda Schwartz for her help in preparing this manuscript.

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Manuscript Guidelines

All scientific manuscripts should be submitted on an IBM compatible disc in Wordperfect 5.1 or in ASCII (generic). They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced on white bond paper, and have the page numbers printed in the right-hand corner of each page.

All manuscripts should include:

1. Title page
2. An abstract of no more than 150 words
3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively. No more than 25 references will be published free of charge.
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

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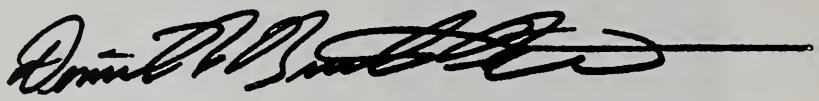
President's Page



Rationed ~~Managed~~ Care

If there were more truth in advertising in the health insurance industry, there would be no such product as managed care. In fact, let's quit calling it that and call it what it really is...rationed care!

Realistically, you cannot take the same number of health care dollars (or less, depending on the plan), interpose a management (re: bureaucratic) layer between the physician and patient, and still deliver the same level and quality of services. You know that, and I know that, but it's time we started telling our patients and the public this fact.

Health insurance executives are making huge profits from our professional expertise and training at the expense of our patients' well-being. I'm sorry, but you can't convince me that patients receive the same level of care in plans where doctors receive **FINANCIAL INCENTIVES TO WITHHOLD CARE.** It ought to be against the law! At the very least, these physicians should feel they're violating the trust of their patients. I'll bet Hippocrates is spinning in his grave.

Two recent studies emphasize this feeling. In an HMO in California (what a great state), women had a 25% higher mortality from breast cancer due to delayed diagnosis and primitive treatment. In another study, HMO physicians commonly misdiagnosed classic signs and symptoms associated with myocardial infarction because of disincentives for care. All the while, executives with these large managed care firms reap million-dollar salaries. Isn't this a great country!

Furthermore, I resent the fact that someone with little or no health care experience or training, and in many instances without so much as a college degree, can interpose themselves into the hallowed doctor-patient relationship. How can anyone sitting in front of a computer tell me what's best for my patient? They can never have that sixth sense or "gut-feeling" that many times leads to the correct diagnosis or treatment. Science may account for 80%-90% of medicine, but it's that other 10%-20% of our work that is the art of medicine.

Oh, and about that current adage on everyone's lips that *"managed care is coming"* -- I have some startling news. It will not come unless we, the doctors, allow it. As far as I know, the Board of Medicine only grants licenses to physicians to practice medicine. Until that changes, I think we should resist this travesty with every moral fiber of our being. We may not win, but we owe it to ourselves, and most of all to our patients (who will find out far too late what has been perpetrated upon them), to fight the good fight.

Go forth -- educate yourselves, your patients and your legislators about this tragedy. Be sincere and tell the truth, they'll understand. Exposed, this issue speaks for itself. It is not too late. I don't know about you, but I'm already tired of this thing called ~~managed~~ rationed care.

— Dennis M. Burton, M.D.

The Journal

The *Journal* never did make money -- even in the heady days when pharmaceutical companies vied for a favorable position for their ad copy. As you may have noticed, those days are long gone. That pharmaceutical ad money now goes to the fancy travel throw-away inserts in various other magazines and to that pile of four-color junk mail you get from the U.S. Post Office every day.

But with ad revenues down, the drain has become too much for the WVSMA to bear. Expenses need to be cut, we are told. Beginning with the next issue, the *Journal* will become a bimonthly publication. The next issue will be the March/April edition and the *Journal* will continue in this manner accordingly on an every other month basis.

Tradition is the bedrock upon which any organization builds and grows. Our *Journal* was first published in August 1906, and it has been a monthly publication since July 1907. It pains the members of the Publication Committee, your editor and staff to subvert such a tradition, but reality inevitably forces change. We are costly. It is some small comfort to note that in its initial year, the *Journal* was a bimonthly production. After that first year, however, its value was so evident that a monthly publication schedule was established. Cost figures in the red have been fought over many times in the past, but the communicative value of the *Journal* has heretofore held the day.

Perhaps we are overcommunicated these days. We do grow tired of the din of present day *communicators* telling us what is good or bad, charitable or selfish, safe or dangerous, chic or gross, even what we should like or dislike. We are admonished to communicate with our spouses, our children, our neighbors, our friends and our enemies. There are too many experts, self-styled and otherwise, out in the world today and it seems as though they are all communicating with us simultaneously, and very noisily.

It's like nerve deafness. The background communication noises keep drowning out the worthwhile or sought-for sounds. Maybe the *Journal* should claim victimhood and apply for a federal grant.

We hope that the *Journal* continues to provide for our readers a few moments of peace, tranquility and thoughtful meditation, if no longer monthly, then at least, bimonthly. We would like to hear from our readers on the changes commented upon here or on any other subject.

The *Journal* will continue to be the primary medium for exchange of thoughts between the WVSMA and its members. We welcome and encourage your side of this interchange. Perhaps there are some ideas out there that would be an improvement on at least one idea emanating from Council recently.

— Stephen D. Ward, M.D.

At Annual Meeting

Mayo Clinic biochemistry professor to present Flink Address on the use of genes in medicine

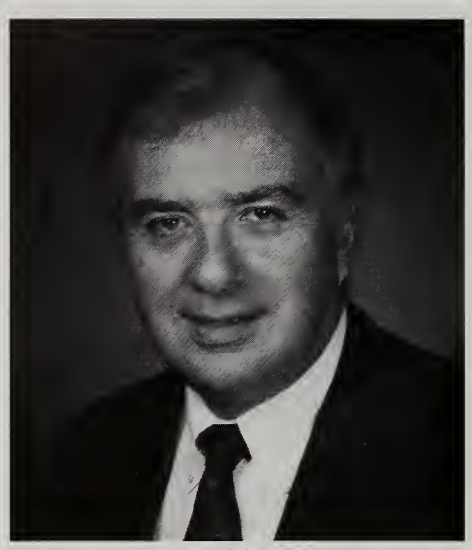
Clarksburg native **Thomas C. Spelsberg, Ph.D.**, who is the George M. Eisenberg Professor of Biochemistry at the Mayo Clinic, will return to West Virginia in August to deliver this year's Edmund B. Flink Address at the WVSMA's 128th Annual Meeting at The Greenbrier. His lecture is entitled *"Genes, Their Replication, Expression and Uses in Medicine,"* and it will be presented during the First Session of the WVSMA House of Delegates on Friday, August 18 at 9:30 a.m.

Dr. Spelsberg received both a B.S. degree in biology and chemistry, and a Ph.D. degree in biochemistry and genetics from West Virginia University. After earning his Ph.D. in 1967, Dr. Spelsberg completed further training at the University of Texas M.D. Anderson Hospital and Tumor Institute in Houston, where a year later he joined the faculty as an assistant professor of biochemistry.

In 1970, Dr. Spelsberg relocated to Nashville, Tenn., to become an assistant professor of biochemistry at the Center for Reproductive Biology at the Vanderbilt University School of Medicine, where he was a fellow of the National Genetics Foundation. Three years later, Dr. Spelsberg left Vanderbilt to became an associate professor of biochemistry and a consultant in the Department of Molecular Medicine at the Mayo Clinic in Rochester, Minn.

Since he joined the Mayo staff in 1973, Dr. Spelsberg has held a variety of administrative roles, including serving as head of the Section of Biochemistry, as secretary to the medical staff officers and councilors, and as president-elect of the medical staff. Currently at Mayo, Dr. Spelsberg is the George M. Eisenberg Professor and chairman of the Department of Biochemistry and Molecular Biology, as well as an endowed distinguished investigator in medical research and president of the medical staff.

A noted researcher and inventor, Dr. Spelsberg has been studying the biochemistry and molecular biology of subcellular processes for the past 25 years. He presently holds several NIH grants for research and has been awarded six U.S. patents.



Spelsberg

During his career, Dr. Spelsberg has received numerous awards, including being named Teacher of the Year at the Mayo Clinic in both 1984 and 1985, and being named to the Alumni Hall of Fame at WVU in 1993. A noted speaker throughout the world, Dr. Spelsberg has been honored as a distinguished lecturer by six universities and medical institutions, and has written more than 200 papers and reviews.

Flink Address

The Edmund B. Flink Address was established by Derrick L. Latos, M.D., F.A.C.P., five years ago when he was president of the WVSMA, to honor Dr. Flink, a professor emeritus at WVU. Dr. Flink was chief of medicine for 16 years at WVU in Morgantown, and then in 1976, he became a Benedum professor who also served as an attending physician at the Robert C. Byrd Health Sciences Center of WVU until his death in 1992.

During his career, Dr. Flink had a major influence on medical education for many physicians in the state, including Dr. Latos who had been one of his students. Dr. Latos created the Flink Address not only to recognize Dr. Flink, but to provide an annual lecture involving internal medicine.

This year's WVSMA Annual Meeting will again take place during the same week as the West Virginia State Fair, so if you wish to stay at The Greenbrier, phone the hotel at 1-800-624-6070 as soon as possible for reservations.

Please turn to page 65 for more details about the meeting or phone the WVSMA at (304) 925-0342.

Nine loss prevention seminars scheduled

The dates and locations for loss prevention seminars presented by Medical Assurance of West Virginia, Inc. are listed below. For more details or to register, please phone Chuck Ellzey or Steve Brown at (304) 346-8228 or 1-800-331-6298.

Thursday, April 27	**6 p.m.**	**The Stratford, Wheeling**
Friday, April 28	**11 a.m.**	**J.T.'s Restaurant, Morgantown**
Saturday, April 29	**8:30 a.m.**	**Days Inn, Clarksburg/Bridgeport**
Saturday, May 20	**8:30 a.m.**	**Holiday Inn, Martinsburg**
Thursday, June 22	**11 a.m.**	**Marriott, Charleston**
Friday, June 23	**11 a.m.**	**Beckley Hotel, Beckley**
Saturday, June 24	**8:30 a.m.**	**Holiday Inn, Bluefield**
Thursday, July 13	**6 p.m.**	**Blennerhasset, Parkersburg**
Saturday, July 15	**8:30 a.m.**	**Radisson Hotel, Huntington**

WVAAFP's 43rd scientific assembly set for Morgantown

The 43rd Annual Scientific Assembly of the West Virginia Chapter of the American Academy of Family Physicians will take place at Lakeview Resort in Morgantown from April 7-9, with special preconference events set for Thursday, April 6.

The first preconference activity, the 14th Annual Golf Tournament, will tee off at 11 a.m. on Thursday, April 6 at Lakeview. At the same time, a seminar on managed care will also begin, and it will be held from 11 a.m. - 5 p.m. Following a buffet dinner at 5 p.m., an "*Obstetrical Update*," will be presented by faculty from both the Morgantown and Charleston Divisions of the Robert C. Byrd Health Sciences Center of WVU. Topics to be discussed include *"General Obstetrical Update," "Vaginal Birth After C-Section (VBAC)," "Hypertension in Pregnancy," "Birth Control: Postpartum and in General," and "Intrauterine Growth Rate (IUGR).*

On Friday at 7 a.m., the conference will officially start with registration and a continental breakfast. After a welcome by William L. Harris, M.D., president-elect of the WVAAFP and program chairman, the first lecture "*Managing Pancreatitis,*" will be presented by Jamie Barkin, M.D., of the University of Miami in Miami. The other lectures that morning will be *"New Trends in Hormone Replacement Therapy,"* by Philip M. Sarrell, M.D., of Yale University; *"Stress Management: Depression,"* by Otis Baughman III, M.D., of Spartanburg Regional Medical Center in Spartanburg, S.C.; and *"Antibiotics in Pediatrics,"* by Willis M. Gooch III, M.A., M.D., of the University of Utah.

Following lunch, the meeting will reconvene with presentations on *"Pathophysiology of Asthma,"* by James E. Fish, M.D., of Jefferson Medical College in Philadelphia; *"Triggers and Pathogenesis of Asthma,"* by William J. Calhoun, M.D., of the University of Pittsburgh School of Medicine; *"Acid Related Disorders,"* by Colin Howden, M.D., of the University of South Carolina; and *"A Practical Approach to New Developments in Management of Lipid Disorders,"* by Eliot A. Brinton, M.D., of the Bowman Gray School of Medicine in Winston Salem, N.C. That evening, an alumni party and an all-member party are planned.

Saturday's events will also start with registration and a continental breakfast at 7 a.m. In addition, a breakfast for

Barkin

Golish

Beaser

resident directors has also been scheduled to begin at this same time.

The morning's four lectures will then take place at 8 a.m. starting with *"Pollen Time and the Livin' Is Sneezy,"* by Bruce Woolley, Pharm.D., of Provo, Utah. The other three morning are entitled *"Drugs and the Kidney,"* by T. K. S. Rao, M.D., of Kings County Hospital in Brooklyn; *'Acute Exacerbations of Bronchitis and Pneumonia,"* by Joseph Golish, M.D., of the Cleveland Clinic Foundation; and *"Developmental Pharmacology: How Drugs React Differently in Children,"* which will also be presented by Dr. Woolley.

A variety of special luncheons and the presentation of the golf trophies will take place from 11:30 a.m. - 1 p.m., and then the scientifics sessions will reconvene at 1:30 p.m. The afternoon topics will include *"Gynecologic Health in Women With Cognitive Disabilities,"* by Caryl Heaton, D.O., of the New Jersey Medical School in Newark, N.J. Other lectures that afternoon will be *"Metabolic Complications of Obesity,"* by Tim Jackson, M.D., of Waynesburg, Pa.; *"Obsessive Compulsive Disorder,"* by Duncan Clark, M.D., of the Western Psychiatric Institute and Clinic in Pittsburgh; and *"Bacterial Vaginosis,"* which Dr. Heaton is also presenting.

On Saturday evening, a reception is being sponsored by Bristol Myers Squibb and Mead Johnson Nutritional, and then the annual banquet and installation of officers will take place, followed by an after dinner, dessert/cordial party sponsored by Eli Lilly.

After registration and a continental breakfast on Sunday at 7:30 a.m., the four concluding scientific sessions will be conducted. The first speaker will be Jay Marion, M.D., of the University of Missouri in Columbia, Mo., discussing *"AHCPR Guidelines on Cancer Pain Management: Coverting Principles into Practice."* The next physician to talk will be Paul Roda, M.D., of Hazelton, Pa., whose lecture is entitled, *"Jack Kevorkian: Right Problem, Wrong Solution."*

After a break, the last two speakers, John Simelaro, D.O., of Philadelphia, and Richard S. Beaser, M.D., will deliver their presentations. Dr. Simelaro will discuss *"Current Trends and Controversies in Asthma and COPD Therapy,"* and Dr. Beaser will talk about *"Diabetes Control and Complications Trial (DCCT): Are Primary Care Physicians Liable If the New Standards of Diabetes Care Are Not Adopted in Their Practice?"*

This meeting has been reviewed and is acceptable for 21 prescribed hours by the AAFP. AOA credit toward Category 2-A for 21 prescribed hours is also approved.

For more information, phone the WVAAFP at 776-1178.

Ethics subject of Beckley seminar

Dr. Sidney Callahan of Mercy College will be the keynote speaker for *"Medical Ethics in Pluralistic America: Consensus and Conflict,"* a seminar being presented by the Southern West Virginia Network of Ethics Committees in Beckley on April 21.

A variety of panels and small group discussions will be presented at this seminar.

For reservations and more information, contact Dr. R. C. Belding at (304) 253-8520.

WVU conference to honor Dr. Stullken

Stullken

The Robert C. Byrd Health Sciences Center of WVU in Morgantown is sponsoring a half-day CME conference on *"New Directions in Medicine,"* on Friday, March 17 in honor of Edward H. Stullken Jr., M.D., chair of the Department of Anesthesiology at the WVU School of Medicine. Due to a serious illness, Dr. Stullken has resigned his positions as chair of the board of the WVU Medical Corporation and as medical director of both the Integrated Provider Network and WVU Hospitals Operating Room, Recovery Room and Same Day Care Unit.

To recognize Dr. Sullken's many achievements and contributions to WVU, a permanent, endowed fund has been established at WVU entitled The Edward H. Stullken Jr. Lectureship: New Directions in Medicine. This fund will be used to support an annual CME program on new directions in medicine in various fields.

This first program will include talks by John Tinker, M.D., and Frank James, M.D., department chairs at the University of Iowa School of Medicine and Bowman Gray School of Medicine, on recent changes in administration, curriculum, and medical practice at their institutions. In addition, Robert Dickler, vice president of the Division of Clinical Services of the Association of American Medical Colleges, will speak on the growth of managed care; and William Fleming, Ph.D., chair of the WVU Department of Pharmacology and Toxicology, and Robert Johnstone, M.D., professor and interim chair of the WVU Department of Anesthesiology, will discuss new developments in pharmacology and anesthesia.

There is no fee for this conference, but pre-registration is required. This event has been certified by the WVU Office of CME for three credit hours in Category 1 of the Physician's Recognition Award of the AMA.

To receive a registration form and brochure, or donate to the fund, phone (304) 293-3980.

Tenth Medicolegal Investigation of Death Seminar set for April 8

This year, the *"Tenth Medicolegal Investigation of Death Seminar,"* will be conducted at the Robert C. Byrd Health Sciences Center of WVU in Morgantown on April 8.

This workshop is sponsored by the Office of the Chief Medical Examiner - the WVU School of Medicine, the State of West Virginia, and four law enforcement agencies and associations. The guest speaker will be Patrick E. Besant-Matthews, M.D., of Dallas. Topics to be covered include shotgun wounds, estimation of the time of death, blunt and sharp force injuries, and postmortem changes.

Contact the Chief Medical Examiner Office at (304) 293-5569 for more details

Huntington agency for the blind conducting feasibility study

Blind Ambition, Inc., a non-profit corporation in Huntington that provides employment for people who are blind, is conducting a feasibility study to assist the agency in establishing a free lending service for adaptive equipment. The equipment may be made available to people who are blind throughout the West Virginia.

According to Blind Ambition's President Robert Kresmer, the study will require speaking to as many blind individuals as possible, and the agency hopes to identify an employment pool of blind persons who are proficient in the use of adaptive equipment.

For more information, phone Blind Ambition at 1-800-778-7787.

Courses offered for evaluating job-related injuries, illnesses

Skills necessary to evaluate a worker's job-related injury or illness will be presented in two *"Impairment and Dis/Ability Evaluations"* courses developed by the American College of Occupational and Environmental Medicine (ACOEM).

These courses are designed for physicians and others involved in medical, legal and administrative work associated with Worker's Compensation and disability management systems, and will be held throughout the U.S. in 1995.

ACOEM is offering a fundamentals course March 25-26 in Lahaina, Maui, Hawaii; May 6-7 in Las Vegas; June 9-10 in Atlanta; Sept. 15-16 in New Orleans; and Oct. 28-29 in Seattle, Wash. A new, advanced course will be presented March 27-28 in Lahaina, Maui, Hawaii; June 11-12 in Atlanta; and Sept. 17-18 in New Orleans. Either course meets one requirement of the American Board of Independent Medical Examiners.

Contact the ACOEM at (708) 228-6850 for more information.

Health care data management subject of Chicago meeting

ICM Conferences, Inc. is sponsoring a seminar entitled *"Information management in the New Healthcare Market,"* which will be presented at the Hyatt Regency Hotel in Chicago from March 15-16.

This conference is designed for physicians and other health care practitioners and administrators involved with creating cost-effective, integrated health information networks in medical practices, hospitals and other health care institutions.

Phone ICM at (312) 540-3010 for additional information.

ARA plans legislative summit in Washington

The American Rehabilitation Association will hold its First Annual Legislative Summit from March 13-14 at the Hyatt Regency in Washington, D.C.

This summit is designed to provide an analysis of rehabilitation issues and networking opportunities.

Phone (703) 716-4009 for more details.

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Please be sure to make hotel reservations early by calling (800) 624-6070. Rooms at The Greenbrier will fill up quickly because the State Fair will take place during the same week.

For information about other hotels in the area, contact the WVSMA at (304) 925-0342. For your convenience, you may register for the conference by calling the above number and using your Visa or Master Card.

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

Charleston Area Medical Center - Charleston

March 2
(Teleconference) "Pharmacotherapy in Sepsis," Todd A. Armstrong, Pharm.D., noon

March 8
"Ethics Conference: Medical Futility," RCBHSCWVU,* Charleston

March 10-11
"Managing Cardiac Arrhythmias in the 90s," RCBHSCWVU,* Charleston

March 16
(Teleconference) "Conservative Management of Renal Failure Patients," Asif Rahman, M.D., noon

**Robert C. Byrd Health Sciences Center of WVU*

Robert C. Byrd Health Sciences Center of WVU - Morgantown

March 13
"Clinical and Molecular Genetics: Applications to Ophthalmic Disease" (sponsored by WVU Dept. of Ophthalmology)

March 17
"New Directions in Medicine" (new annual CME program in honor of Edward H. Stullken Jr., M.D.)

March 24-25
"Urology Update" (sponsored by the WVU Dept. of Urology)

April 3-5
"Awareness to Action III - Fetal Alcohol Syndrome Training Workshop (sponsored by WVU Dept. of Behavioral Medicine and Psychiatry and West Virginians for FAS Action), Days Inn, Flatwoods

April 8
"Tenth Medicolegal Investigation of Death Seminar" (sponsored by the Office of the Chief Medical Examiner and the WVU Dept. of Pathology)

April 21
Third Annual Stephen C. Rector Visiting Lectureship in Emergency Medicine (sponsored by WVU Dept. of Emergency Medicine), RCBHSCWVU,* Morgantown

**Robert C. Byrd Health Sciences Center of WVU*

Marshall University - Huntington

March 15
"Ob/Gyn Grand Rounds: Clinical Challenges in Contraception," Trent MacKay, M.D., Cabell Huntington Hospital, 7 a.m.

March 20
"Research Day Opening Lecture," Marshall University Student Center, 7 p.m.

March 21
"8th Annual Research Day," Holiday Inn Gateway, 8 a.m.

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *Charleston Area Medical Center, Charleston*

Fairmont ★ Fairmont Clinic, March 15, 1 p.m., "Head Injury," Howard Kaufman, M.D.

Gassaway ☐ Braxton County Memorial Hospital, March 6, 6:30 p.m., "Risks and Indications of Blood Transfusions," Mary Taylor, M.D.

Logan ☐ Logan General Hospital, March 17, 11:45 a.m., "Post-Op Complications of Acute MI," Rakesh Wahi, M.D.

Man ☐ Man Appalachian Regional Hospital, March 15, 6:30 p.m., "Suicide Assessment and Prevention," Tom Ellis, Ph.D.

Martinsburg ★ VA Medical Center, March 2, 3 p.m., "Depression," Paul Clausell, M.D.

Montgomery ☐ Montgomery General Hospital, March 1, 12:30 p.m., "Treatment of Osteoporosis," Alfred Pfister, M.D.

New Martinsville ★ Wetzel County Hospital, March 9, noon, "Coronary Risk Factors," Anthony Morise, M.D.

Parkersburg ★ Camden-Clark Memorial Hospital, March 15, 7:30 a.m., Evaluation of a Neck Mass," Mark Wax, M.D.

★ Camden-Clark Memorial Hospital, March 29, 7:30 a.m., "TBA,*" Robert Keefover, M.D.

Philippi ★ Broaddus Hospital, March 2, 1 p.m., "Chronic Pelvic Pain," Thomas Harman, M.D.

Point Pleasant ☐ Pleasant Valley Hospital, March 23, noon, "Post MI Surgical Complications," Rakesh Wahi, M.D.

Richwood ☐ Richwood Area Medical Center, March 9, 5:30 p.m., "Cancer Prevention Screening," Arvind Kamthan, M.D.

Ripley ☐ Jackson General Hospital, March 10, 12:30 p.m., "Treatment of Osteoporosis," Alfred Pfister, M.D.

Waynesburg, Pa. ★ Greene County Memorial Hospital, March 14, 7 p.m., "Vertigo and Dizziness," Alvaro Gutierrez, M.D.

**TBA - To Be Announced*

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PHYSICIAN'S RECOGNITION AWARDS

We wish to congratulate the following WVSMA members who recently received Physician's Recognition Awards from the AMA for voluntarily completing 150 credit hours of continuing medical education during the past three years.

Cabell
Charles Abraham, MD
Narendra Kumar Bora, MD
Roy A. Edwards, MD
Kenneth M. Fink, MD
Hyla M. Harvey, MD
Robert A. Hess, MD
Helen Y. How, MD
Gary Lemasters Ripley, MD
William E. Triest, MD
Joseph B. Touma, MD

Central
Arnold E. Gruspe, MD
Clyde P. Mitchell, MD

Eastern Panhandle
Orlando I. Agnir, MD
Peter Edwin Ferguson, MD
Vettivelu Maheswaran, MD
John Sylvester Palkot, MD
Danine A. Rydland, MD

Greenbrier
Everett J. Kennedy, MD
Harvey A. Martin, MD
Houston Burger Moore, MD

Hancock
George M. Roig, MD

Harrison
James Allen Arnett, MD
Arthur L. Calhoun, MD
James A. Genin, MD
Robert D. Hess, MD
Edgardo F. Sarino, MD
Milagros F. Ona-Sarino, MD

Kanawha
Thomas R. Douglass, MD
Robert E. O'Conner, MD
Alberto C. Lee, MD
Jerry A. Maliska, MD
Jerome D. Massenburg, MD
Desingu S. Raja, MD
Frank J. Trupo, MD
Martin Stuart Wershba, MD

Logan
Rolando M. Gellegani, MD

Marion
Kenneth Hilsbos, MD
Jack S. Koay, MD
Donald M. Koppel, MD
John Thomas Porvaznik, MD

Marshall
Kenneth Jean Allen, MD

Mercer
Gopal M. Pardasani, MD
Bhasker Rad Pujari, MD
Joel A. Schor, MD

Monongalia
Richard W. Eller, MD
William L. Hall, MD
Roy Gregory Juckett, MD
Jyoti M. Patel, MD
Hassan H. Ramadan, MD
Edward Henry Stullken, MD
Richard Martin Vaglienti, MD
Stephen Jeffrey Wetmore, MD

Ohio
Terry A. Athari, MD
John P. Donahue, MD
John Thomas Dorsey, MD
Cheryl H. Pixley-Entress, MD
John W. Kennard, MD
Michael A. Fortunato, MD

Parkersburg Academy
Loretto M. Auvil, MD
David W. Avery, MD
John E. Beane, MD

Raleigh
Yolanda A. Santos, MD
Syed Abdul Zahir, MD

Tygart's Valley
Donald C. Carter, MD
Samuel K. Roberts, MD

Wyoming
Haleem J. Rasool, MD

This page of material is submitted and paid for by the Bureau for Public Health.

Improvements for state's public health system outlined by PHAC

The Public Health Advisory Council (PHAC), appointed last June by the Commissioner of the Bureau for Public Health (BPH), has developed a list of recommendations for improving the public health system in West Virginia. Council members presented the plan to public health and community representatives during a teleconference in early January, and to the Governor's Joint Committee on Health Reform prior to the beginning of the legislative session.

The main recommendations of the PHAC are as follows:

Public Health's role and mission will be focused on providing the core public health functions identified by the federal Centers for Disease Control and Prevention and by the Institute of Medicine. The objectives of the core public health functions are to:

* Prevent epidemics and the spread of disease
* Protect against environmental hazards
* Prevent injuries
* Promote and encourage healthy behaviors
* Respond to disasters and assist communities in recovery
* Assure the quality and accessibility of health services
* Monitor the health status to identify community problems
* Diagnose and investigate health problems and health hazards in the community
* Inform, educate and empower people about health issues
* Mobilize community partnerships and action to solve health problems
* Develop policies and plans that support individual and community health efforts
* Enforce laws and regulations that protect health and ensure safety
* Link people to needed personal health services and assure the provision of health care when otherwise unavailable
* Assure an expert public health workforce
* Evaluate effectiveness, accessibility and quality of health services
* Research for new insights and innovative solutions of health problems.

Public Health saves lives and saves money. Although 71% of early deaths in West Virginia could be prevented by population-based public health approaches, only 11% could possibly be prevented by additional medical treatment. Investing more in Public Health will place the focus on this 71%, helping to prevent needless illness and to reduce associated medical expenses.

In order to accomplish this, the PHAC recommends strengthening the public health infrastructure, first - - by strengthening the Local Public Health Infrastructure by:

* Establishing public health standards
* Requiring certification for meeting standards
* Conducting community health assessments
* Measuring progress in addressing major health problems
* Assuring public health facilities meet ADA handicapped access requirements
* Providing essential funding to local health through: phased-in increases in the state aid to local agencies requirements of local financial support for public health
* Providing new technical assistance through Local Public Health Cooperatives
* Designating one representative for each county that joins a cooperative
* Assuring access to personal clinical services and protecting local health financial stability during the 5-year transition, in part by mandating managed care organizations consider local health departments as "essential access providers"

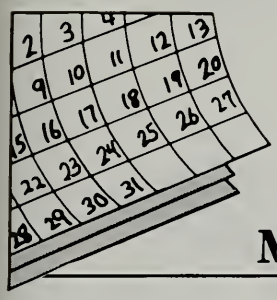
Due to a lack of funds for core public health functions, some revenues for clinical health services have helped cover the cost of essential public health services such as immunizations and water testing. In West Virginia, 32% of the funds going to public health are for personal clinical services and could be lost to public health in a managed care system.

Certain technical assistance and services are costly and may best be offered through public health cooperatives. The PHAC recommends local boards of health join together voluntarily to form Local Public Health Cooperatives. These local entities would be responsible for providing Public Health technical assistance in the areas of:

* Epidemiology services and disease tracking
* Automation and public health data management
* Health promotion
* Public health workforce training and education
* Input toward the development of the State Health Plan
* Representation on the State Public Health Advisory Council

The PHAC recommends a new state PHAC be established to do state health planning and policy development, and to address training and education of the public health workforce. The public health system within West Virginia is currently unable to fulfill the minimum requirements of many core functions. Having faced neglect while the medical care system rallied for dollars and attention, the public health system throughout the U.S. suffered a relative decline of 25% funding over the past decade.

For more details about the plan, call the BPH at 558-2971.



Medical Meetings

March

11-16–5th Annual Mammography Update (sponsored by SMA), Amelia Island, Fla.

14-19–Toward an Electronic Patient Record '95: Eleventh International Symposium on the Creation of Electronic Health Record Systems and Global Conference on Patient Cards (sponsored by Medical Records Institute), Orlando

18–West Virginia Chapter of the American College of International Physicians, Charleston

18-22–Society For Biomaterials Annual Meeting and Exhibition, San Francisco

24-25–West Virginia Urological Society/ WVU Annual Update Meeting, Morgantown

24-26–Caring for People with Chronic Health Conditions (sponsored by SMA), Hilton Head Island, S.C.

25–Substance Abuse '95: Programs in Policy and Practice (sponsored by George Washington University), Washington, D.C.

29-April 1–The 2nd Annual Oncology Conference (sponsored by Mississippi Baptist Medical Center), Bermuda

31-April 2–New Drugs Update: Indications, Interactions, Efficacy and Cost Analysis (sponsored by SMA), Biloxi, Miss.

April

2-4–15th Annual Meeting of the American Society for Laser Surgery, Inc., San Diego

7-8–Dyslexia: Assessment and Clinical Management of Language-based Disorders (sponsored by Menninger Clinic), Topeka, Kan.

7-8–The Shoulder Symposium: Rotator Cuff -- Current Concepts 1995 (sponsored by SMA), Pine Mountain, Ga.

7-9–American Society of Abdominal Surgeons, Las Vegas

7-9–Association of Reproductive Health Professionals, McLean, Va.

19-22–American Burn Association, Albuquerque, N.M.

19-23–Mid-America Orthopaedic Association, Palm Beach, Fla.

21-22–Clinical Innovations in Ob/Gyn Ultrasound (sponsored by Meetings & Management Techniques Plus), Washington, D.C.

21-27–American Society of Neuroradiology, Chicago

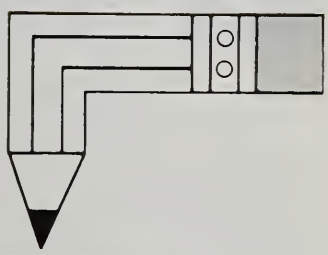
22-27–American Association of Neurological Surgeons, Orlando

25-28–Interhospital '95 (sponsored by Hannover Fairs USA, Inc.), Hannover, Germany

27-30–West Virginia Academy of Ophthalmology's 48th Annual National Spring Meeting, White Sulphur Springs

For More Information . . .
Contact the Journal at (304) 925-0342.

Poetry Corner



Alexis

Somewhere there is song
to speak unto my soul

Somewhere there is song
to mend and make me whole

Somewhere there is sun
to warm my upturned face

Somewhere there is sun
to make me know of Grace

Somewhere there is rain
to melt away the snow

Somewhere there is rain
to coax the earth to grow

Somewhere there is snow
to cover bare brown ground

Somewhere there is snow
to brighten a dingy town

Somewhere there is goodness
to speak unto my soul

Somewhere there is kindness
to mend and make me whole

P. Van Swearingen, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

ROBERT C. BYRD HEALTH SCIENCES CENTER

OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

Cardiologists use new tool to treat CAD

Jain

Cardiologists at WVU are using a new tool called a Rotablator, a high-speed drill-like device, to fight coronary artery disease.

"The Rotablator, which rotates at about 160,000 to 250,000 rpm, has a diamond head that actually shaves and pulverizes the plaque clogging an artery," Dr. Abnash C. Jain, professor of medicine and chief of the Section of Cardiology said. "The shavings, which are smaller than red blood cells, are absorbed by the body. The Rotablator leaves the arterial wall smooth and allows blood to flow freely.

"This is not the case with balloon angioplasty, which uses a balloon to compress the plaque and leaves the arterial wall rough, causing more blood flow resistance. In patients treated with the Rotablator, there's only a 20% chance that the arterial plaque will return. With balloon angioplasty, the odds increase to 30%-35%.

"Because of these advantages, the majority of patients who in the past would have been treated with balloon angioplasty will not go away. In some patients, it will continue to be the best treatment option."

Kolbenschlag presents lectures in Japan

Madonna Kolbenschlag, Ph.D., clinical psychologist with University Health Service, recently gave a series of lectures in Japan on *"Myth and Culture"* and *"Women's Development."*

Dr. Kolbenschlag met with students, professors, students, psychologists and psychiatrists, and with the Japanese translator of some of her writings.

New radiology center named in honor of Dr. Ian W. Marshall

Marshall

The Department of Radiology is building a new training and academic resource center as a memorial to the late Dr. Ian W. Marshall, who completed his radiology residency at WVUH in 1993. The Ian W. Marshall Radiology Training Center will be dedicated this spring.

The center, which will be housed in a renovated area of the old University Hospital, will provide the highest quality radiology training facilities and environment. In addition to providing work stations equipped with view boxes and CD-ROM facilities, laser video disc and videotape facilities will be available, along with MDTV access.

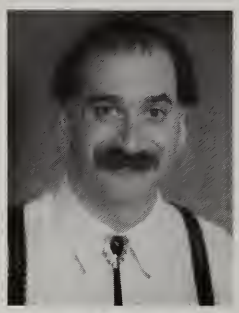
Med schools launch four wellness projects

Four West Viriginia communities - - Barboursville, Cabin Creek, Clarksburg and Monroe County - - will be the sites for new wellness programs launched by the state's medical schools.

"We intend to involve thousands of people in improving their own health and the health of their families," says Bill Reger, Ed.D., of the WVU School of Medicine's Department of Community Medicine.

WVU's Morgantown campus will work with Clarksburg and Bridgeport residents in a nutrition education campaign, and the WVU Charleston campus will work with the Cabin Creek Community Health Center to develop a school-based wellness project. In addition, MU will join with the community council at Village Medical Center in Barboursville to establish a wellness resource center, and the WV School of Osteopathic Medicine is helping Monroe County residents convert a former school building into a wellness center.

Two otolaryngologists present papers



Wax

Ramadan

Drs. Mark Wax and Hassan Ramadan, assistant professors of otolaryngology, presented papers at a recent meeting of the Southern Section of the Triologic Society.

Dr. Wax's paper was entitled *"Current Concepts in Contemporary Management in Cerebrospinal Fluid Rhinorrhea,"* and Dr. Ramadan's paper discussed *"Endoscopic Sinus Surgery in Developmentally Delayed Children."*

Mandich named interim chair of PT

MaryBeth Mandich, P.T., Ph.D., associate dean for allied health sciences and undergraduate education in the School of Medicine, has been named interim chair of the Division of Physical Therapy.

Sandy L. Burkhart, P.T., Ph.D., stepped down as chair at the end of 1994. He will remain a member of the physical therapy faculty. Dr. Burkhart has been a faculty member in the physical therapy program since 1970, and was named director in 1980.

Dr. Mandich joined the faculty in 1980, and was named associate dean in 1994.

Jarvis-Eckert to attend White House meeting

Dr. Marilyn Jarvis-Eckert, the WVU Center on Aging's associate director for community service and outreach, will attend the White House Conference on Aging in May, which has been called by President Clinton.

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Marshall University School of Medicine

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

MU rated 2nd in U.S. in percentage of grads entering primary care

Marshall now ranks No. 2 in the U.S. in the percentage of graduates entering primary care practices, according to new figures released by the Association of American Medical Colleges (AAMC).

With 42 percent of graduates entering careers in family practice, general internal medicine and general pediatrics, Marshall shares the second-place ranking with Southern Illinois University; the Mercer University School of Medicine ranks first with 44 percent. Three MU officials have stated in an exhibit presented at the AAMC annual meeting in October that Marshall's success in cultivating generalist physicians can be linked to the use of "community classrooms."

"Marshall integrated the rural primary care focus into its programs at every level, from student selection to post-residency support," according to the abstract presented by Dr. Patrick I. Brown, Dr. Linda M. Savory and JoAnn Raines. "The school capitalized on its community-based structure by supplementing its hospital affiliations with linkages to rural practices."

Marshall uses such classrooms in several key programs, they noted, including:

·A mock epidemic, in which volunteers in Hamlin open their offices and homes to students trying to sharpen their epidemiological skills;

·An integrated course on Health Promotion and Disease Prevention that provides first- and second-year medical students with ongoing primary care experiences;

·The Rural Physician Associate Program, in which selected third-year students spend nine months working with a rural physician; and

·The Kellogg Community Partnership program and the Rural Health Initiative, through which Marshall cooperates with the state's other health professions schools to offer students experiences at more than 125 sites.

The AAMC rankings of 125 U.S. medical schools showed Marshall was one of just four that had 40 percent or more of their graduates enter primary care; the average rate was 25 percent. The AAMC study was based on medical school graduates in 1988, 1989 and 1990 who completed residencies in the primary care fields without entering subspecialty training by the 1993-94 academic year. Using percentages derived from historical data, researchers then calculated how many of those graduates are likely to remain in primary care fields.

MU also ranks second among U.S. medical schools in the percentage of graduates entering family practice residencies, according to a separate study released last fall by the AAFP. The school has held that position for two years.

Study reveals large number of ER visits by teenagers unnecessary

Marshall researchers reported in a recently published study that the number of visits teenagers made to the Cabell Huntington Hospital Emergency Department would have been sliced in half and an estimated $100,000 saved, if those patients had their own doctors and used them appropriately.

The study, published in the *Journal of Adolescent Medicine*, looked at visits that 12- to 18-year olds made to the Cabell Huntington Hospital Emergency Department in 1989. It was conducted by Dr. Christoph Lehmann, chief resident in pediatrics; Dr. Jane Barr, now an alumnus of the Marshall School of Medicine; and Dr. Patricia Kelly, associate professor of pediatrics.

In reviewing charts of 4,932 visits, the researchers found that patients were more likely to use the emergency room inappropriately if they did not have private insurance or access to a telephone. Half of the patients did not have private insurance and 41 percent had no identified primary care source. One-fifth did not have access to a telephone.

Nearly half of the emergency room visits studied were for injuries, 64 percent of them cuts or minor injuries. Respiratory and other infections also were frequent complaints. After reviewing the charts, researchers concluded that about half of the cases could have been treated just as well in a doctor's office or clinic - - significantly lower-cost options.

"The lowest cost of an ED visit for a `cold' ... was $84 at Cabell Huntington Hospital in 1989 compared an average $46 for a visit to a local university-affiliated pediatric clinic," the researchers said. "This definitely imposes higher costs, especially on the uninsured. "Primary care sources are needed that are accessible and acceptable to adolescents," the researchers concluded.

Variety of events scheduled for Eighth Annual Research Day

People interested in medical education and research are invited to attend Marshall's Eighth Annual Research Day on March 21 from 8 a.m. - 6 p.m. at the Holiday Inn Gateway Convention Center near Barboursville.

Research Day showcases projects by medical students and residents, and awards are given for outstanding studies. This year, Dr. Frank Torti of Wake Forest University will be the keynote speaker for the event. In addition to speaking at the Research Day luncheon, he will give an opening lecture at 7 p.m. on March 20 in the Marshall University Student Center. Dr. Torte's opening lecture will be open to the public.

Registration information is available from the Office of Continuing Medical Education at 696-7019.

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Alliance News

A mid-year report

Since our WVSMAA "year" runs from mid August to mid August when we conduct our annual convention, this is the perfect time to reflect on several important issues.

MEMBERSHIP

It may be confusing to some Alliance members that our "year" at the state level runs from mid August to mid August because most counties run their years from May to May or something similiar; and our membership year at the state and national levels is the calendar year! We start collecting dues in the fall so that they can be turned in by the first of the year, but we can continue collecting and turning in state and national dues through March. Our AMAA delegate number is based on the dues that have been recorded with the AMAA by March 31, so it is very important to mail in your dues as soon as possible.

HAVE YOU OR HAS YOUR PHYSICIAN SPOUSE PAID YOUR ALLIANCE DUES?

HAS YOUR COUNTY ALLIANCE TREASURER SENT YOUR DUES TO THE STATE TREASURER?

If there is not a county chapter in your area, you can still be a member through our member-at-large category. Contact the WVSMAA Vice President Amy Ricard at 736-6974 or phone Winnie Morano, our executive secretary at 925-0342. Membership is the easiest way to support the work that the Alliance does in West Virginia for physicians and health care. Let your money support our efforts, even if you can't!

HEALTH PROJECT

By now, all members should be aware that my project for the year is *"Combating the Negative Effects of Media on Children and Youth."* What have you done for this project! The least you could do is put a stack of our brochures in your spouses' medical practice, a toy store, a children's clothing store, your church or pass them out at PTA. These brochures aren't only for parents of children - - they are for grandparents, uncles, aunts, neighbors and friends of children and teens.

MEDICAL ALLIANCE MONTH

The AMAA president has designated March as Medical Alliance Month - - a time to make the public aware of what the Alliance does for the health of the community.

WHAT DOES YOUR COUNTY HAVE PLANNED FOR THIS EVENT? How about - - A feature article in the local paper highlighting the various projects your chapter has conducted over the years? - - Having your mayor declare March as Medical Alliance Month? - - Tieing in Medical Alliance Month with the celebration of Doctor's Day? Putting an ad in the local paper telling what the Alliance does to support health care?

LEGISLATION

Since the Legislature is in session right now, are you aware of all issues being discussed which may impact on the practice of medicine? Read the *Legislative Updates* that are mailed to you each week and call the WVSMA's Legislative Hotline at 1-800-257-4747 every weekday after 4:30 p.m. for updates on events at the Legislature. Make sure your county phone bank is operational and offer to help.

AMA-ERF

Have you donated to AMA-ERF yet? Please contribute to this valuable fund which helps our future physicians pay for their educations and perform special medical research. If you want to, you may designate on your check which medical school you would like to receive your funds, otherwise they will be divided equally.

Sue Bryant
WVSMAA President

Component Society News

FAYETTE

Dr. Ziad Kahwash was the guest speaker for the January meeting of the Fayette County Medical Society. His lecture was entitled *"Hypoglycemia."*

Business issues that were discussed at the meeting included the possibility of having more local speakers, and the option of having the WVSMA handle the society's dues billing. No motions were made about these two matters.

At the society's February meeting, Dr. Hassan Ajmad, the president of the Fayette County Medical Society, requested that Dr. Tony Bazzi of Beckley Appalachian Regional Hospital discuss the hospital's application to HCCRA for a Certificate of Need to construct an Ob/Gyn addition. Dr. Bazzi asked the members to back the hospital's application by writing letters to HCCRA and Governor Caperton.

Following dinner, which was sponsored by Debby Hon, regional representative of Pfizer Pharmaceutical Company, the guest speaker Dr. Arturo Pasqual was introduced. Dr. Pasqual, an assistant professor of medicine and a staff physician in the Nephrology and Hypertension Division at Henry Ford Hospital in Detroit, presented the lecture *"Renal Disease and Hypertension: An Update.*

After a question and answer session, Dr. V. S. Diwan of Pineville opened the business meeting with his request that the society approve a medical care plan backed by the UMWA and the Westmoreland Coal Company. No action was taken.

Dr. Oscar Gosien, vice president of the society, then moved that members write letters as requested by Dr. Bassi, and this motion passed unamiously.

McDOWELL

The January meeting of the McDowell County Medical Society was conducted on January 26 in the dining room of Welch Emergency Hospital following the hospital's medical staff meeting.

Dr. Alexander Herland, the society's past president, opened the meeting with a summary of the proceedings of the recent WVSMA Council Meeting and other events conducted during the WVSMA/WV-ACP Mid-Winter Seminars and Scientific Conferences in Huntington.

Mr. Nelson Todd of the *Welch Daily News* had a lengthy conversation with Drs. Carr, Anderson and Herland in which he expressed the interest of the local press in publishing a series of articles about the McDowell County Medical Society and its involvement in community health, economic, political and social issues in the area.

At the meeting, it was also decided to change the dates of the society's future meetings to coincide and follow the Welch Emergency Hospital's medical staff meetings. In addition, the members expressed their thanks to Mary Stillwell, editor of the *Welch Daily News*, for her cooperation and interest in covering local events and people that might in anyway be noteworthy to the area residents, and also for her accurate reporting.

MERCER

Dr. Syed Tasnim Raza of the Department of Cardio-Thoracic Surgery at Buffalo General Hospital at the State University of New York at Buffalo, was the guest speaker for the Mercer County Medical Society's meeting on January 16. His talk was devoted to the subject of thoracic surgery in Bosnia - Herzegovina, and the extreme difficulties all surgeons are experiencing there due to the disruption in normal activities.

At the society's February meeting, the lecture *"Allergic Rhinitis"* was presented by Donald Asbury, M.D., a board certified allergist. This CME program included a dinner and was sponsored by the Bluefield Regional Medical Center and the Allen & Hanburys - Division of Glaxo, Inc.

MONONGALIA

Alice Faryna, M.D., medical director of Medicare Operations for Nationwide Insurance, spoke on the subject of *"Medicare Evaluation Guidelines Documentation for Nationwide"* for the January meeting of the Monongalia County Medical Society.

The featured speaker for the society's next meeting on February 7 was Dr. David Knitter, medical director of respiratory therapy for Monongalia General Hospital. His presentation was entitled *"Update on Respiratory Infection."*

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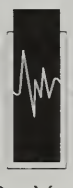

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Obituaries

Arsenio M. Orteza, M.D.

Dr. Arsenio M. Orteza, 62, of Morgantown, died October 24 at Mon Pointe Continuing Health Care Center.

Dr. Orteza was born on December 5, 1931, in Butuan City in the Philippines. After graduating from the College of Medicine of the University of the Philippines, Dr. Orteza interned at Philippine General Hospital in Manila and then came to the U.S. for an internship at Evangelical Deaconess Hospital in Cleveland. He completed a one-year residency in pathology at Sinai Hospital in Baltimore, Md., and then completed a three-year residency in general surgery at Reading Hospital in Reading, Pa.

In 1963, Dr. Orteza relocated to Morgantown, where he continued his postgraduate studies with a three-year residency in general surgery. Following his residency, Dr. Orteza joined the faculty of the WVU Medical Center, where he practiced urology and surgical urology.

A member of the Christian and Missionary Alliance Church, Dr. Orteza was also a past West Virginia state and local Gideon chaplain.

Dr. Orteza is survived by his wife, Janice Wass Orteza; a son, Arsenio Orteza of Opelousas, La.; a daughter, Grace Orteza of Arlington, Va.; a stepson, Dr. Charles T. Wass of Rochester, Minn.; three brothers, Ephraem Orteza of Morgantown and Benjamin Orteza and Ruben Orteza, both of the Philippines; two sisters, Dr. Josephina Orteza of Morgantown and Evelina Orteza of Calgary, Canada; and a grandson.

Dr. Orteza was preceded in death by his first wife, Clara F. Orteza; three brothers and a sister.

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Horatio Adolph Spector, M.D.

Dr. Horatio Adolph Spector, 77, of Charleston, died October 11 at CAMC of pancreatic cancer.

A native of Boston, Dr. Spector received his medical degree from the Ohio State College of Medicine in 1942. He interned at Charleston General Hospital, and then served with the U.S. Army for three years at an evacuation hospital in the South Pacific. Following his military service, Dr. Spector completed a residency at Bethesda Hospital in Cincinnati.

In 1947, Dr. Spector began practicing in Winifrede, W.Va, taking care of coal miners and their families. He was known for his dedication to his patients, and the Rev. Forrest Cooper, who officiated Dr. Spector's funeral, has been a patient since those days in Winifrede.

"He was an awful good doctor, so patient and kind," Cooper recalled in an article in the *Charleston Daily Mail.* "He wouldn't try to hurry you up. He was a good listener."

Cooper's whole family, including his wife and five grown sons were still Dr. Spector's patients.

Goldie Jacobs, who worked for Spector for 24 years, was also interviewed by the *Charleston Daily Mail* after Dr. Spector's death, and she said there were other patients from the coal mines who, like Cooper "remained his patients all through the years."

For them and others, Dr. Spector practiced an old-fashioned kind of medicine. "No matter what the hour, he went," Jacobs said. "If they couldn't pay him, that was fine, too. He took care of them anyway."

Dr. Spector had no survivors, but according to Jacobs, "His office was his family. He had a giant family because he was the man he was," she added.

Dr. Spector was a member of the Masons and he played violin for many years in the Charleston Symphony, holding first chair for 25 or 30 years. He had found out about his cancer just three weeks before his death, and he worked at his office in the Medical Staff Building at CAMC's Memorial Division until the day he entered the hospital.

Memorial contributions may be made to Kanawha Hospice Care Inc., 1143 Dunbar Avenue, Dunbar, W.Va., 25064.

Elliott L. Thrasher, M.D.

Dr. Elliott L. Thrasher, 83, died November 25 at Sistersville General Hospital.

Dr. Thrasher was born on September 1, 1911, in Bridgeport, W.Va. He received his bachelor's degree from West Virginia University in 1933 and his medical degree from the Medical College of Virginia in 1937. After Dr. Thrasher served his internship in 1938 at Ohio Valley General Hospital in Wheeling, he began practicing general medicine in Sistersville, where he cared for patients until his retirement in 1988.

During his career, Dr. Thrasher served on the board of directors for the Union Bank of Tyler County and Sistersville General Hospital. In addition to being a member of the WVSMA, he was a member of Sistersville United Methodist Church; Phoenix Lodge No. 73 AF & AM in Sistersville; Nemesis Shrine Temple in Parkersburg, and a 32nd degree Scottish Rite Mason.

Surviving are his son, Dr. Elliott Thrasher of Lexington, Mass.; two daughters, Mary Foglesong of Seoul, South Korea, and of Red Lodge, Mont., and Sara Bradley of Houston, Texas; and six grandchildren.

Dr. Thrasher was preceded in death by his wife, Marie Suter Thraser, in 1979.

Memorial contributions may be made to Sistersville General Hospital, 314 S. Wells St., Sistersville, W.Va., 26175.

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Front Cover

A lady slipper heralds the return of spring to Greenbrier County. Photo courtesy of Stephen Shaluta Jr., West Virginia Division of Tourism and Parks.

SPECIAL SECTION

Mid-Winter Clinical Conference

Highlights of the West Virginia State Medical Association's
1995 Mid-Winter Seminars and Scientific Conferences

January 19-22, 1995

Radisson Hotel
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We want to thank all of the participants of the WVSMA's 1995 Mid-Winter Seminars and Scientific Conferences for their support which is vital for the continued success of this annual CME event.

Dr. Mabel Stevenson of Huntington holds her pride and joy, her granddaughter Erin, while Erin's parents, Drs. F. Anthony Wolfe and Deirdre M. Marshall of Miami, deliver their presentations for the First Scientific Session.

Dr. F. Anthony Wolfe, clinical professor of plastic and reconstructive surgery at the University of Miami School of Medicine, presented a fascinating lecture with his wife, Dr. Deirdre M. Marshall, entitled *"Peripatetic Plastic Surgeons: Benefactors of Mankind or Innocents Abroad?"*

WVSMA President-Elect Dr. James Helsley offers a comment about managed care to WVSMA President Dr. Dennis Burton and the guests at the luncheon for component society and specialty society presidents, as well as executive secretaries.

Dr. Robert Marshall, governor of the West Virginia Chapter of the American College of Physicians (right), proudly poses with the newest recipients of the WVACP's Laureate Awards Dr. Robert D'Alessandri (far left) and Dr. William O. McMillan Jr. (fourth from left), as well as Dr. Oscar Edwards, governor of the Virginia Chapter of the ACP, and Dr. Warren Point, a former governor of the WVACP and former Laureate Award recipient.

At the conclusion of the Third Scientific Session, Moderator Dr. Maurice Mufson of Marshall University, talks with one of the speakers, Dr. Robert Belshe of the St. Louis University School of Medicine, about his lecture on "AIDS."

Elvis Presley, alias Dr. Ronald Hill of West Virginia University, made a surprise appearance on Saturday evening during the laser karaoke show presented by Dr. Rano Bofill.

Guest speakers Dr. Woodrow Myers of Associated Group in Indianapolis, and Dr. Michael Tanner of the Cato Institute in Washington, D.C., prepare to respond to a participant's question during the Physician/Public Session on *"Health Reform/ Managed Care."*

Dr. Jimmie Mangus and Dr. Elizabeth Spangler of CAMC visit with Dr. Bill Atkinson of Parkersburg and Dr. David Hess of Clarksburg in the Exhibit Hall.

Dr. Hina Trivedi of Huntington listens intently to the lecture on *"New Concepts in Gastro-esophageal Reflux Disease and Ulcer Disease"* during the First Scientific Session.

The medical versus surgical treatment of coronary artery disease was the focus of one of the *"Controversies in Medicine"* sessions, which featured Dr. Ronald Hill, associate professor of surgery at WVU, and Dr. Robert Touchon, professor of medicine at Marshall University.

Managed care -- to some it's humorous, to some it's not...WVSMA Executive Director George Rider and his wife, Dot, share a laugh over some remarks made by the speakers during the Physician/Public Session on *"Health Reform/Managed Care,"* while Dr. Bill Atkinson looks on with a more serious expression.

In the Exhibit Hall, physicians and guests visit the representatives at the booths for Aspire, Inc., Abbott Laboratories and St. Francis Hospital.

During their annual meeting, members of the WVSMA's Medical Student Section enjoyed listening to lobbist Bill Perry's interesting perspective of the inner workings at the West Virginia Legislature.

During the First Scientific Session, WVSMA President Dr. Dennis Burton delivered a moving tribute to his friend and fellow radiologist Dr. Ian Marshall of WVU, who died unexpectedly last year. Dr. Marshall is the son of Dr. Robert Marshall and Dr. Mabel Stevenson of Huntington.

WVSMA Vice President Dr. Ronald Cordell directs a comment to Drs. Judith Schreiman and Daniel Foster during the *"Controversies in Medicine"* session on screening mammography.

Dr. Rano Bofill (right) presented trophies to the winners in the laser karaoke competition which took place on Saturday evening during the meeting. Pictured with Dr. Bofill are Steve Brown of Medical Assurance; Tamara Lively, Michelle Sull Myers and Heather Sipes of Acordia; Dr. Frank Scattaregia of Weston; Gary Lively, Tamara's husband; WVSMA Associate Executive Director Nancie Albright; and WVSMA Council Chairman Dr. James Comerci.

The popular electric slide brought guests at the laser karaoke show out on the dance floor.

How low can you go? AMA Field Representative Amy Bishop joined in for some limbo fun during Saturday night's entertainment.

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The Greenbrier will fill up quickly because the State Fair will be going on during the same week. For more information, call the WVSMA office at (304) 925-0342.

Thoracic outlet syndrome with arm ischemia as a complication of cervical rib

ALI F. ABURAHMA, M.D.
Professor of Surgery, Department of Surgery, Robert C. Byrd Health Sciences Center of West Virginia University, Charleston Division; and Chief of the Vascular Section and Medical Director of the Vascular Laboratory, Charleston Area Medical Center, Charleston

JOHN F. WHITE III, M.D.
Chief Surgical Resident, Charleston Area Medical Center/Robert C. Byrd Health Sciences Center of West Virginia University, Charleston Division

Abstract

Thoracic outlet syndrome is the causative factor in less than 5% of patients with upper extremity ischemia. Congenital bony abnormalities (cervical rib) are most often responsible for the arterial complications of this syndrome.

This article presents the case report of a patient who presented with ischemia of an upper extremity caused by embolization from subclavian artery stenosis and an aneurysm secondary to cervical rib. The treatment plan included excision of the cervical rib, repair of the subclavian artery aneurysm and a bypass graft which achieved a satisfactory outcome.

Introduction

Thoracic outlet syndrome is the causative factor in less than 5% of cases of upper extremity ischemic syndrome with congenital bony abnormalities, including cervical rib which is most often responsible for the arterial complications (1).

In this article, we report the case of a patient who presented with ischemia of the hand and forearm caused by embolization from subclavian artery stenosis and subclavian artery aneurysm secondary to cervical rib.

Case report

A right-handed, 33-year-old white female was referred to the Vascular Surgery Service at Charleston Area Medical Center for a vascular evaluation of her right upper extremity. Her history revealed a two-year history of numbness and discoloration of her right upper extremity. Initially, these symptoms were only exacerbated by cold weather, however, three to four months prior to her examination at the Vascular Surgery Service, she had begun to have pain in her right arm while working for an extended period of time. This pain was initially relieved by rest, but progressed to rest pain associated with a white and blue discoloration of the right hand.

This patient's medical and family history, as well as her general exam, were unremarkable. Her vascular exam was normal except for faint axillary, brachial, radial, and ulnar pulses by palpation with a monophasic Doppler signal. Her Doppler brachial pressure was 118 mmHg in the left arm and 64 mmHg in the right arm.

Further laboratory studies and a non-invasive vascular work-up were then conducted. Her lupus anticoagulant, antinuclear antibody, sedimentation rate, antithrombin III, proteins C and S, prothrombin time, and activated partial thromboplastin times were all within normal limits. Duplex examination revealed monophasic waveforms in the right subclavian, axillary and brachial arteries with a peak systolic frequency range from 6-7 KHZ, which was suggestive of severe stenosis of the right subclavian artery. A chest radiograph showed no abnormality other than a right cervical rib (Figure 1).

Subsequently, this patient underwent an arteriogram which showed significant stenosis of the right subclavian artery associated with aneurysmal dilatation corresponding to the site of the cervical rib compression near its attachment to the first rib. The right brachial artery was occluded with reconstitution by multiple collaterals at the elbow. There was also occlusion of the mid-radial artery with incomplete palmar arches present (Figures 2 and 3).

We decided to perform decompression of the thoracic outlet and vascular reconstruction under general anesthesia. The cervical rib, anterior and median scalene muscles were excised through a supraclavicular transverse incision.

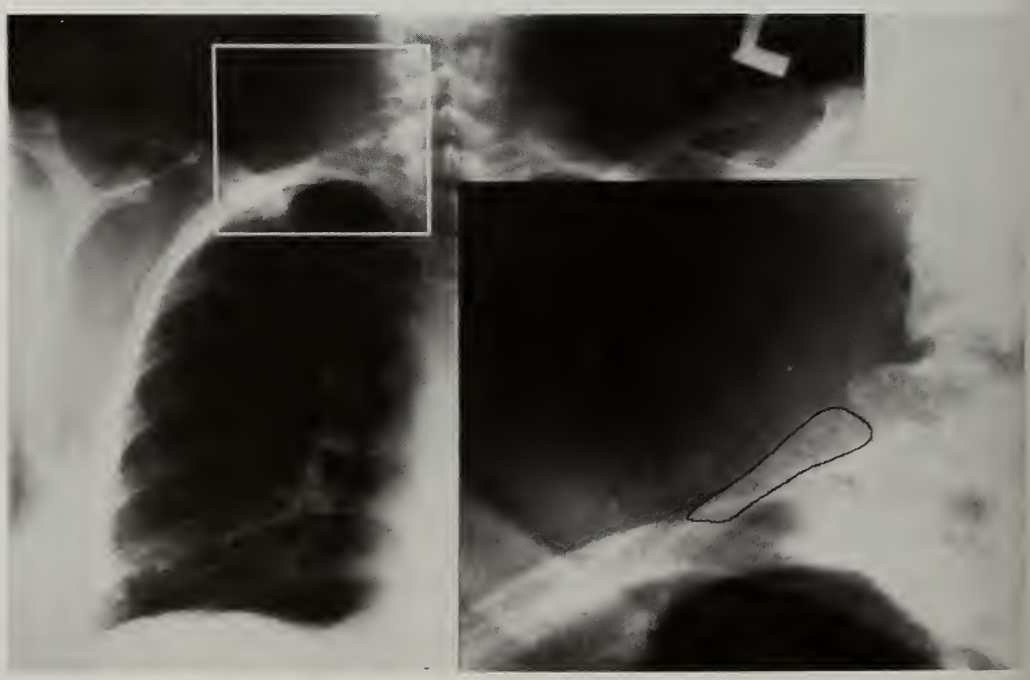

Figure 1. Chest radiograph showing no abnormality other than a right cervical rib.

Figure 2. Arteriogram showing significant stenosis of the right subclavian artery associated with aneurysmal dilatation.

Figure 3. Arteriogram showing the occluded right brachial artery with reconstitution by multiple collaterals at the elbow.

Vascular reconstruction was achieved by proximal and distal ligation of a 3 cm subclavian artery aneurysm and insertion of a polytetrafluoroethylene (Goretex, W. L. Gore, Gore and Associates, Inc., Flagstaff, Ariz.) bypass graft between the proximal subclavian artery and the axillary artery. A transverse infraclavicular incision was utilized to expose the axillary artery.

Intraoperative and postoperative evaluations revealed good biphasic Doppler signals in both the brachial (at the elbow level) and radial arteries (at the wrist level). Postoperatively, the patient progressed well and was discharged home after five days.

One year later, subsequent non-invasive vascular studies showed the graft to be patent with biphasic Doppler signals. Furthermore, this patient achieved full function and returned to her job as an elementary school cook.

Discussion

Thoracic outlet syndrome results in signs and symptoms referable to the structures exiting the interscalene triangle, i.e. the brachial plexus, subclavian artery, and subclavian vein. Narrowing of the thoracic outlet results most frequently in neurological symptoms in approximately 95% of patients. Another 4% of patients present with venous problems (subclavian vein thrombosis), and only about 1% present with arterial insufficiency.

As previously mentioned, arterial insufficiency in thoracic outlet syndrome is commonly associated with bony abnormalities, with the greatest percentage of these being complete or incomplete cervical ribs (1,2). Other less common etiologies include elongation of the transverse process of the 7th cervical vertebra, congenital abnormalities of the first thoracic rib, acquired abnormalities of the clavicle and a hypertrophic scalenus anterior muscle.

In the presence of congenital or acquired narrowing of the interscalene triangle, compression and localized stenosis of the subclavian artery may occur. At anytime during this course, damage to the artery can ensue either as a result of localized stress to the intima or flow disturbance just beyond the area of compression. These changes may result in atherosclerotic subclavian artery stenosis and/or dilatation with mural thrombus formation that may cause thromboembolic complications of the upper extremity, which can be limb threatening.

A patient presenting with arterial insufficiency of the upper extremity will often initially complain of cold-induced pain and discoloration. If unilateral, this Raynaud-type symptom is always due to a proximal vascular lesion and should not be attributed to the more benign vasospastic form of Raynaud's disease (3). Progression of this disease as a result of thoracic outlet compression may cause common symptoms associated with ischemia. Pain is often caused by exercise and relieved by rest, however, pain while at rest ultimately occurs with progression of atherosclerosis or embolic disease. Dysesthesia and paresthesia may develop, as well as color changes and poikilothermia. Furthermore, loss of pulses and a significant difference in brachial arm pressures may be apparent.

Duplex imaging and segmental Doppler arm pressures are useful studies initially to evaluate the upper extremity ischemia and thoracic outlet syndrome. However, an arch aortogram with selective injection of the innominate or subclavian artery is necessary to evaluate the extent of arterial compromise, whether it be stenosis, aneurysmal dilatation or thromboembolic.

Once an arterial lesion is diagnosed, operative therapy is usually needed since there is no "conservative" approach to this complicated disease. Often, simple decompression of the thoracic outlet will suffice. However, circumstances may supervene to dictate thoracic outlet decompression accompanied by vascular reconstructive procedures for any of the secondary

complications. Decompression is performed for arterial disease via a supraclavicular incision. This allows good exposure for the required scalenectomy, as well as for treatment of osseous abnormalities.

Subsequent reconstruction of arterial flow may then be undertaken with the proximal subclavian artery serving as the inflow source. As in our patient, exclusion of an embolic source, if present, is mandatory. Bypass may then be carried out with a polytetrafluoroethylene graft, Dacron prosthesis or autogenous reverse saphenous vein.

Results of early intervention are very good. As noted, most patients will benefit from decompression alone and almost all can expect long-term improvement (4). As our patient's case has shown, even those individuals with more significant disease who require reconstruction can expect a reasonable outcome as a result of improved inflow to a vascular bed rich with collaterals.

The importance of this case and others like it is to reinforce the awareness of clinicians to this condition which, if treated early, has excellent results, and if found late can be very costly in terms of morbidity and mortality.

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Left atrial myxoma: A case presentation and review of the literature

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Abstract

Cardiac myxomas account for 24% of all primary cardiac tumors. The majority occur in the left atrium and are attached via a pedunculated stalk. The presentation may mimic primary myocardial dysfunction or obstructive valvular disease. Frequently, the diagnosis is delayed secondary to only vague constitutional symptoms. In this article, we present a case of a left atrial myxoma discovered after thoracic surgery in a patient with elevated pulmonary pressures thought to be secondary to mitral stenosis, and demonstrate how transesophageal echocardiography is useful in the evaluation of critically ill patients with cardiac tumors.

Case report

A 72-year-old female with a known history of hypertension was brought to the emergency room of a hospital near Morgantown suffering from respiratory arrest and was intubated immediately. For the previous eight months, she had been experiencing a progressive shortness of breath and cough which had eluded diagnosis. Her medications consisted of only an unknown antihypertensive agent.

Several hours after arriving at the emergency room, she developed hemodynamic instability and a chest X-ray revealed mediastinal emphysema. Bronchoscopy indicated a traumatic tracheal tear and she was transported on an emergency basis to West Virginia University Hospital for surgical repair. She arrived in critical condition and was taken immediately to surgery where her trachea was repaired.

During surgery and in the immediate postoperative period, this patient was noted to have near systemic pulmonary pressures. An EKG revealed normal sinus rhythm, right axis deviation, and right ventricular hypertrophy. The diagnosis of mitral valve stenosis was entertained and an emergent, transthoracic, 2D echocardiogram showed a large echo density within the left atrium. A transesophageal, 2D, echocardiogram was then obtained which provided the definitive diagnosis of a large inhomogeneous, pedunculated atrial myxoma, arising from the interatrial septum of the left atrium. This myxoma was causing near total obstruction of the mitral valve during diastole and obstruction of pulmonary venous return during systole.

An emergency resection resulted in gradual normalization of this patient's pulmonary pressure, as well as normalization of her EKG with normalization of axis and resolution of her right ventricular hypertrophy. Pathologic examination of the mass confirmed left atrial myxoma. After a lengthy hospitalization, this patient recovered and was discharged.

Discussion

The incidence of primary cardiac tumors remains low, despite advances in their detection and diagnosis. Primary cardiac tumors have an incidence of 0.0017% and myxomas are the most common form, accounting for 24% of all cases (1,2). Seventy-five percent of myxomas occur in the left atrium, 18% in the right atrium, and the remaining 7% are divided between the right and left ventricles (1).

The presentation of atrial myxomas may occur as hemodynamic or obstructive symptoms, as symptoms secondary to emboli, or as constitutional manifestations (1,2). The constitutional manifestations are vague and non-specific so the diagnosis by these symptoms alone is very difficult. The most common constitutional symptoms and laboratory findings are fever, weight loss, palpitations, myalgia, arthralgia, elevated erythrocyte sedimentation rate, anemia, leukocytosis, and fatigue (1,2,3). The etiology of these symptoms and findings is debated, but they may be secondary to an immunologic response to the tumor, emboli or degenerating tumor fragments (1).

Of the patients with atrial myxoma, 24%-34% will have emboli (1), and 50%-80% of these will involve the cerebral circulation (4). The source of embolism may be tumor fragments or overlying mural thrombus (2). When tumor fragments embolize, they may behave in a malignant fashion resulting in infiltrative destruction of the arterial wall and subsequent myxomatous pseudoaneurysm formation (2,5). Most authors advocate histologic examination of removed unexplained arterial emboli in young people to exclude the presence of atrial myxoma (1,5).

The hemodynamic effects of atrial myxomas are a result of interference to pulmonary or systemic venous return or to obstruction of one of the atrioventricular valves. The classic presentation of a left atrial myxoma is paradoxical dyspnea, which is dyspnea exacerbated by sitting or standing associated with postural hypotension that is relieved when the patient lies on his or her back (1). Other symptoms may include syncope (produced by atrioventricular valve obstruction), dyspnea, fatigue, sudden death, congestive heart failure, and malaise (1,2). In addition, right-sided myxomas may cause hepatomegaly, ascites, and peripheral edema (1).

Of the three known types of myxomas, the sporadic type is the most common (2). Sporadic type myxomas occur in older patients with a mean age of 50 years old, and the tumor is almost always single, usually located in the left atrium. Synchronous sporadic myxomas are very rare, and the recurrence risk is < 1% (2).

Complex cardiac myxomas carry a high recurrence risk of up to 21% (2). These occur earlier in life, often in the third decade, and are synchronous in 50% of the cases. Patients with complex cardiac myxomas have a 33% chance of having a primary relative similarly affected (2). These tumors are associated with various skin and endocrine lesions, including ephelides, nevi, lentigines, skin myxomas, myxoid mammary fibroadenomas, and unusual testicular tumors (2).

Familial cardiac myxomas are similar to the complex type because they are usually found in younger patients with synchronous tumors (1). They affect members of the same family without the various skin and endocrine abnormalities seen with the complex type, and the recurrence risk is 10% (2).

Physical examination can be helpful in the diagnosis of cardiac myxomas. These patients are usually in normal sinus rhythm (due to the short-term presence of the tumor), as opposed to mitral or tricuspid valve stenosis in which patients are often in atrial fibrillation (1). On auscultation, S_1 is delayed, accentuated, and prolonged; S_2 is increased and delayed (1). A diastolic sound, called the tumor plop, can often be heard 0.05-0.11 seconds after S_2 (1,5). This is probably a result of the tumor suddenly falling into the ventricle in early diastole (1). Various valvular mumurs may be heard, particularly mitral or tricuspid valve regurgitation. Variation in murmurs with time and position is pathognomonic of an atrial myxoma (5).

This patient's first electrocardiogram revealed right ventricular hypertrophy and right axis deviation. To our knowledge, this has not been previously described in the literature and most likely reflects the chronic hemodynamic effects of mitral valve obstruction.

Pathologically, atrial myxomas most often arise near the fossa ovalis and are pedunculated. They are fast-growing tumors with an average growth rate of 1.3 cm/year and 14 g/year (6), and two types have been described. One type is firm and grows to a large size often resulting in the hemodynamic consequences already mentioned (2). The other type is smaller, semitransparent, gelatinous and is much more likely to give rise to emboli (2). Histologically, myxomas consist of an acid mucopolysaccharide matrix with polygonal cells, rare blood vessels, and a monolayer covering of cells similar to those in the enclosed matrix (5).

The diagnosis of atrial myxoma is often difficult on clinical grounds alone. Nomeir and colleagues studied a series of 35 patients with cardiac myxomas over a 20-year period, and only six of these patients were suspected of having cardiac myxomas prior to the echocardiogram (3).

Techniques used for the pre-operative evaluation of cardiac myxomas include transthoracic and transesophageal 2D-echocardiography, magnetic resonance imaging, computed tomography, radionuclide-based scanning, and cardiac catheterization. The mainstay of diagnosis has become 2D-echocardiography because it is simple, extremely accurate, available, and does not carry the risks of radiation exposure or tumor fragmentation (1,2,5).

In the patient we described, transthoracic echocardiography was suboptimal secondary to limited echocardiographic windows caused by thoracic subcutaneous emphysema and generalized edema as well as mechanical ventilation. Transesophageal echocardiography provided clear definition of the tumor size, attachment location, and the degree of obstruction.

The near complete obstruction of left ventricular filling was easily demonstrated using 2D-echocardiography alone (Figures 1 and 2). However, in patients with smaller tumors the degree of obstruction can be quantified using continuous wave Doppler to assess the pressure gradient across the affected valve (7). In addition, transesophageal echocardiography was useful to

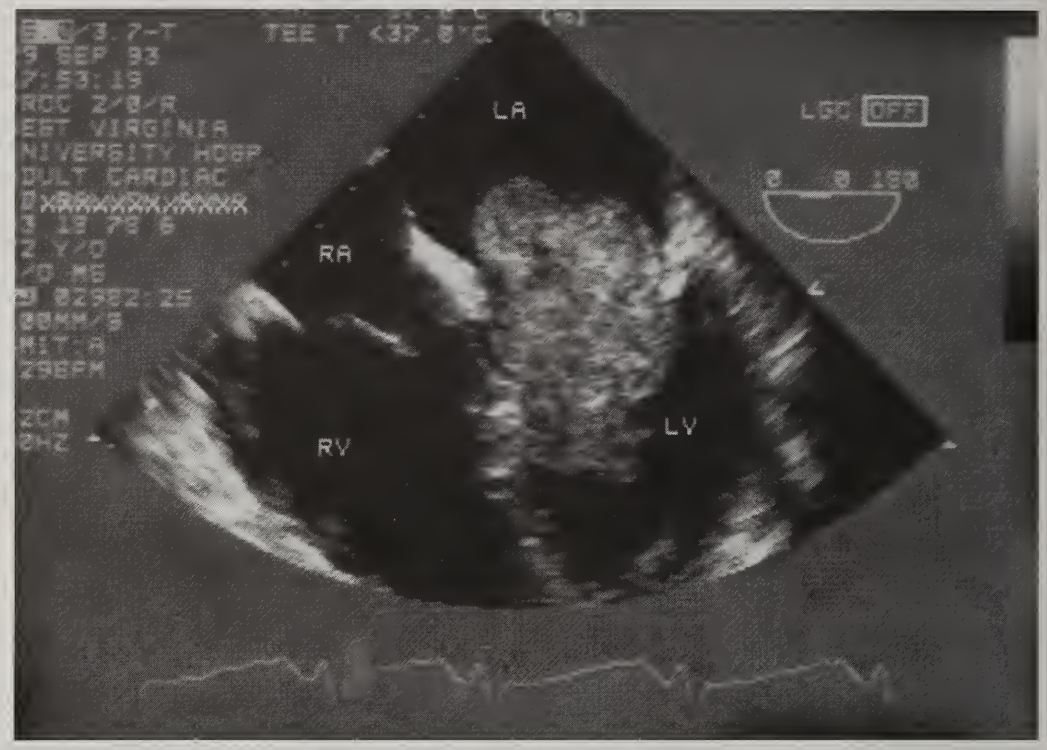

Figure 1. Transesophageal four-chamber view demonstrating near complete obstruction of the mitral valve by the atrial myxoma.

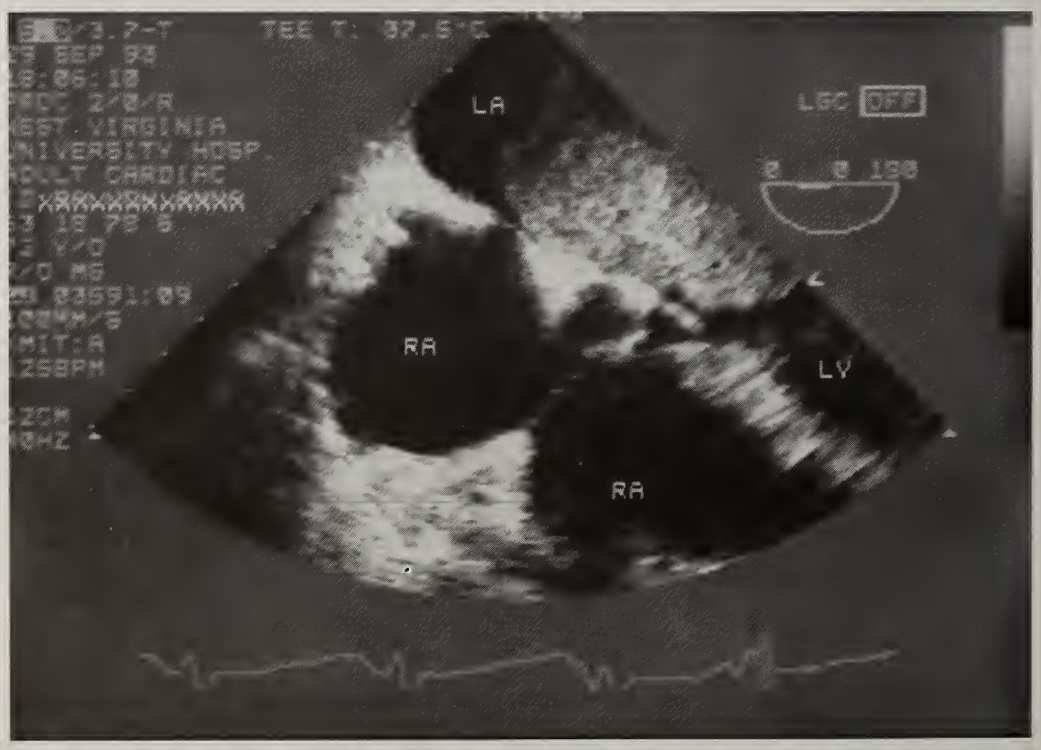

Figure 2. Transthoracic four-chamber view demonstrating attachment of the myxoma to the interatrial septum by a stalk.

evaluate coinciding valvular or ventricular dysfunction. This obviated the need for a left ventricular angiogram and subsequent dye load in this critically ill patient.

The thoracic aorta was also assessed and provided information on calcification and the presence of atherogenic debris which is a potential source of embolization during aorta cannulation for bypass or other hemodynamic support maneuvers. Cardiac catheterization is now generally reserved for those patients thought to have associated coronary disease, and some authors recommend it in all male patients over 40 years old to evaluate the coronary arteries (2).

The treatment for cardiac myxomas is prompt surgical removal because these patients are at great risk for embolism and sudden death (5). For sporadic myxomas, primary resection with a small portion of adjacent endocardium is sufficient (2). However, for familial or complex myxomas, wide-septal excision, including the entire fossa ovale, and patch repair, may be needed (5). Additionally, atrioventricular valve replacement may be necessary due to the wrecking ball effect of the atrial myxoma on the valvular structures (1). Perioperative mortality is about 5% and is primarily due to systemic embolization of peripheral tumor fragments (5).

Follow up is necessary to detect tumor recurrence as well as to check for growth of peripheral embolic tumor fragments (1). Routine follow up by echocardiography is recommended to examine for recurrence, which has been documented as early as six months and as long as 12 years (2,5). For myxomas suspected of being complex or familial, routine screening of first-degree relatives is also indicated (2).

In summary, cardiac myxomas remain rare and even though they are very treatable, many patients have died with this condition because it was so difficult for physicians to diagnose. Now, with advances in diagnostic techniques, particularly echocardiography, the diagnosis can be made promptly.

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All scientific manuscripts should be submitted on an IBM compatible disc in Wordperfect 5.1 or in ASCII (generic). They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced on white bond paper, and have the page numbers printed in the right-hand corner of each page.

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3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively. No more than 25 references will be published free of charge.
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

Primary care orthopedics and sports medicine in West Virginia

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Abstract

Previous studies at several family practice residency programs in the U.S. have shown that many family practice graduates feel inadequately prepared to offer fracture care or casting. In order to determine if this was a problem in West Virginia, a survey was sent to all family physicians in the state which asked about their type of practice and residency training, if they provided fracture care or casting services, if they offered sports medicine coverage for teams in their communities, attitudes about their own competency in caring for fractures, as well as other personal and demographic data. Our survey confirmed that only 118 family physicians provide fracture care (42%), and that only 91 provide casting services (32%). The surveys also revealed that rural physicians feel obligated to offer this service, despite the fact that they do not perceive themselves to be very competant in this aspect of patient care, and only 43 rural physicians offer sports medicine coverage (44%). As a result of these findings, we propose that a more adequate orthopedic experience be a part of family practice training, and that there should also be increased emphasis on insuring family practice residents have a basic competency in sports medicine.

Introduction

Several studies conducted at various family practice residency programs in the U.S. have questioned the efficacy of residency training in several subspecialty areas of surgery, especially orthopedics (1,2,3,4,5,6,7). In these surveys, orthopedics and fracture care have repeatedly been mentioned as areas that residents felt they did not receive enough training in to adequately care for patients, and recent studies have shown that when FP residents are afforded the adequate training and experience in orthopedics, they are quite competent at fracture care (8,9).

The Residency Review Committee (RRC) currently requires 200 hours of orthopedic training during the three-year residency period. Often, this is only a single one-month rotation in orthopedics taught by orthopedic surgeons. Unfortunately, during this rotation, outpatient orthopedic care may not be emphasized.

In West Virginia, no studies of FP physicians had been conducted to obtain data about their practice parameters in relation to orthopedic and sports medicine services, as well as their training in these areas, so we composed a survey which was mailed to all active members (non-resident and non-students) of the West Virginia Academy of Family Practice. Since West Virginia is mainly a rural state, we felt this data would be especially significant because there would be an even greater need for orthopedically competent FP physicians due to the fact that most orthopedists tend to gravitate towards urban areas.

Table 1. Characteristics of Family Practice Physicians Responding to Survey

Type of Practice	Frequency	Percent of Total
Private	131	47.6%
Group	103	37.8%
Teaching	40	14.5%
MDs Who Care For Soft-Tissue Injuries	**Frequency**	**Percent**
Yes	266	94.3%
No	16	5.7%
MDs Who Provide Fracture Care	**Frequency**	**Percent**
Yes	118	41.8%
No	164	58.2%
MDs Who Apply Casts	**Frequency**	**Percent**
Yes	91	32.3%
No	191	67.7%
MDs Who Are Team Physicians	**Frequency**	**Percent**
Yes	81	28.7%
High School	66	23%
College	13	5%
No	201	71.3%
MDs Who Had 3-Year FP Residency	**Frequency**	**Percent**
Yes	171	60.6%
No*	111	39.4%
Gender	**Frequency**	**Percent**
Male	237	84%
Female	45	16%
Ages of Participating MDs	**Frequency**	**Percent**
30-39	106	37.6%
40-49	91	32.3%
50-59	52	18.4%
60-69	24	8.5%
Over 70	9	8.2%
Town size of MDs	**Frequency**	**Percent**
10,000 and under	107	37.9%
10K-25K	54	19.1%
25K-50K	65	23%
50K-100K	45	3.9%

*Physicians may have had only internship or residency in specialty other than family practice.

Futhermore, a 1990 article in *Military Medicine* stated that primary care doctors are able to take care of many of the orthopedic diagnoses, especially with continuous longitudinal training (10). Another study in the *British Medical Journal* revealed that up to 43% of orthopedic referrals may have been inappropriate and could potentially have been handled by family practitioners (11).

Methods

A survey consisting of 10 questions was sent to all active members (non-residents and non-students) of the West Virginia Academy of Family Practice who were currently living in West Virginia. Two months following the initial mailing, a second mailing was mailed to the physicians who had not responded. Although not all family practitioners are members in this organization, it was felt that the number of those who were not members would be very small. However, not all members of the WVAFP completed residencies in family practice training (Table 1).

The questions on the survey related to the repondents' type of practice and the size of the town in which it was located, their residency training, gender, age, as well as if they provided fracture care, casting services and sports medicine coverage to local teams, and how they felt about their competency level in these areas of expertise.

The data was analyzed using a chi-square analysis. A p-value of .05 or less was considered to be a significant difference. When cell sizes were small, a likelihood ratio chi-square was utilized.

Results

Of the 401 surveys mailed, 282 surveys were returned, which resulted in a 70% response rate. The initial frequency data can be found in Table 1.

The results indicated that 266 (94%) of primary care physicians were taking care of soft-tissue injuries. However, only 118 (42%) of these physicians treated fractures of any nature, and of these physicians, only 91 (32.3%) were applying casts in their practice. In addition, only 81 of the family practitioners responding provided care at local sporting events.

The statistics pertaining to the care of soft-tissue injuries showed that only one of the modifying factors was significant since almost all physicians were already taking care of these types of problems. The survey results also indicated that the residency training a physician received made a difference in whether or not he/she treated soft-tissue injuries. Of the non-residency trained physicians, 15 elected not to take care of soft tissue injuries, whereas only one of the residency-trained physicians elected not to take care of these injuries ($p < .001$).

Residency training also made a difference as to whether physicians surveyed cared for fractures. Of the non-residency trained physicians, 39 took care of fractures, compared to 79 of the residency-trained physicians (Table 2). This relationship approached, but did not achieve statistical significance ($p = .066$). Although it did not reach statistical significance, the physicians who felt poorly trained in treating fractures, were less likely to provide this type of care than those who felt better trained in this area of expertise. In addition, older physicians were less likely to take care of fractures than younger physicians ($p = .025$); and the small town doctors were slightly more likely to take care of fractures ($p = .065$).

Table 2. FP Physicians and Fracture Care

Type of Practice	Do Offer FC	Don't Offer FC
Private	49 (37.4%)	82 (62.6%)
Group	49 (47.6%)	54 (52.4%)
Teaching	20 (50%)	20 (50%)
p=.187		
Residency Training		
Yes	79 (46.2%)	92 (53.8%)
No	39 (35.1%)	72 (64.9%)
p=.066		
How Well Their Residency Prepared Them		
Very well	9 (40.9%)	13 (59.1%)
Well	35 (52.2%)	32 (47.8%)
Fairly well	49 (45.8%)	58 (54.2%)
Poorly	17 (30.9%)	38 (69.1%)
p=.117		
Gender		
Male	104 (43.9%)	133 (56.1%)
Female	14 (31.1%)	31 (68.9%)
p=.111		
Age		
30-39	47 (44.3%)	59 (55.7%)
40-49	44 (48.4%)	47 (51.7%)
50-59	21 (40.4%)	31 (59.6%)
60-69	6 (25%)	18 (75%)
70+	0	9 (100%)
p=.025		
Population		
-10K	54 (50.5%)	53 (49.5%)
10-25K	19 (35.2%)	35 (64.8%)
25-50K	29 (44.6%)	36 (55.4%)
50-100K	12 (26.7%)	33 (73.3%)
100K+	4 (36.4%)	7 (63.6%)
p=.065		

The survey results pertaining to casting services showed that physicians in a teaching practice were more likely to apply casts ($p = .046$) (Table 3). Residency training again made a significant difference in this skill ($p = .041$). Only eight female physicians utilized casts in their practice (17%), compared to 83 of their male counterparts (35%) ($p = 0.023$). Older physicians were again less likely to provide this service for their patients ($p = .032$). Physicians from smaller towns also had a significantly higher rate of casting in their practices ($p = .029$).

The section of the questionnaire devoted to the subject of sports team coverage revealed that physicians who felt better trained in orthopedics were more likely than their counterparts to participate as team doctors ($p = .001$) (Table 4). In addition, males were more likely than females to provide this community service ($p = .013$).

To gain insight into the practices of rural physicians, we specifically selected out responses from physicians who stated that they did provide fracture care and casting, and practiced in

Table 3. FP Physicians and Casting Services

Type of Practice	Do Offer CS	Don't Offer CS
Private	41 (31.3%)	90 (68.7%)
Group	30 (29.1%)	73 (70.9%)
Teaching	20 (100%)	20 (100%)
p=.048		
Residency Training		
Yes	63 (36.8%)	108 (63.2%)
No	28 (25.2%)	83 (74.8%)
p=.041		
How Well Their Residency Prepared Them		
Very well	8 (36.4%)	14 (63.6%)
Well	26 (38.8%)	41 (61.2%)
Fairly well	37 (34.6%)	70 (65.4%)
Poorly	14 (25.5%)	41 (74.6%)
p=.466		
Gender		
Male	83 (35%)	154 (65%)
Female	8 (17.8%)	37 (82.2%)
p=.023		
Age		
30-39	35 (33%)	71 (67%)
40-49	32 (35.2%)	59 (64.8%)
50-59	21 (40.4%)	31 (59.6%)
60-69	3 (12.5%)	21 (87.5%)
70+	0	9 (100%)
p=.032		
Population		
-10K	43 (40.2%)	64 (59.8%)
10-25K	12 (22.2%)	42 (77.8%)
25-50K	25 (38.5%)	40 (61.5%)
50-100K	9 (20%)	36 (80%)
100K+	2 (18.2%)	9 (81.8%)

Table 4. Sports Team Coverage

Type of Practice	Do Offer STC	Don't Offer STC
Private	36 (27.5%)	95 (72.5%)
Group	33 (32%)	70 (68%)
Teaching	12 (30%)	28 (70%)
p=.748		
Residency Trained		
Yes	51 (29.8%)	120 (70.2%)
No	30 (27%)	81 (73%)
p=.612		
How Well Their Residency Prepared Them		
Very well	8 (36.4%)	14 (63.6%)
Well	32 (47.8%)	35 (52.2%)
Fairly well	28 (26.2%)	79 (73.8%)
Poorly	8 (14.6%)	47 (85.5%)
p=.001		
Gender		
Male	75 (31.7%)	162 (68.4%)
Female	6 (13.3%)	39 (86.7%)
p=.013		
Age		
30-39	31 (29.3%)	75 (70.8%)
40-49	30 (33%)	61 (67%)
50-59	12 (23.1%)	40 (77%)
60-69	7 (29.2%)	17 (70.8%)
70+	1 (11.1%)	8 (88.9%)
p=.559		
Population		
-10K	34 (31.8%)	73 (68.2%)
10-25K	12 (22.2%)	42 (77.8%)
25-50K	23 (35.4%)	42 (64.6%)
50-100K	11 (24.4%)	34 (75.6%)
100K+	1 (9.1%)	10 (90.9%)
p=.241		

rural areas with populations of under 25,000. It was suprising to note that of the physicians in this category, 61% of those who stated that they were not well trained in fracture care, were actually more likely to provide treatment than were their non-rural counterparts who felt well trained (61% vs. 39%). In addition, the physicians who did not provide orthopedic care in rural areas showed no difference in their level of preparedness when compared to those physicians who did practice orthopedic skills (Table 5). However, rural physicians' level of comfort with orthopedics seemed to effect their willingness to provide the service of sports team coverage (Table 6).

Conclusions

Although residency training is devoting only a small percentage of time to orthopedic medicine (1,2,3,4,5,6,7), studies have shown that orthopedic diagnoses ranked second only to cardiac diagnoses in frequency at family practice offices (12). It is thus obvious that medical education needs to evaluate if this lack of emphasis on orthopedic

Table 5. Rural FP Physicians and Orthopedic Care/Sports Team Coverage

Rural FP Physicians Providing OC

How Well Their Residency Prepared Them

	Do Offer OC	Don't Offer OC
Very well	7 (10.3%)	9 (12.7%)
Well	19 (27.9%)	14 (19.7%)
Fairly well	29 (42%)	32 (45%)
Poorly	13 (19.1%)	16 (22.5%)

Rural FP Physicians Providing STC

How Well Their Residency Prepared Them

	Do Offer STC	Don't Offer STC
Very well	6 (14%)	10 (10.4%)
Well	15 (34.9%)	18 (18.8%)
Fairly well	16 (37.2%)	45 (46.9%)
Poorly	6 (14%)	23 (24%)

medicine training is affecting primary care physicians in their practices.

From our study of West Virginia primary care physicians on this subject, we obtained a 70% response rate and were able to conclude that there is definitely a need for medical education to concentrate more on orthopedic training, especially for physicians who will be practicing in rural areas. Our results revealed that even though more residency-trained family practitioners are practicing fracture care than non-residency trained family practitioners, there seems to be much room for improvement. Many rural physicians are taking care of fractures and orthopedic problems, even though they stated they did not feel very competent or knowledgeable about this area of medicine. This is due to the fact that many of these physicians are practicing in rural areas where orthopedic specialists are not located.

Our survey also showed that fewer female family practitioners are performing fracture care, and that older physicians are less likely to provide this type of treatment. No reason was given for fewer females providing this service, but we feel that older physicians are not providing fracture care because of the higher malpractice liability rates associated with this treatment.

As a result of our survey, we feel it is important for all primary care residents to have more training in orthopedic medicine than is now offered by most residency programs. We conclude that there should be at least a bare minimum of a casting clinic once a year where all primary care residents are taught to apply a short-arm and a short-leg cast. In addition, physicians who plan to practice in rural areas should have more advanced orthopedic training which would include casting, simple fracture reduction, principles of fracture care and joint injections. These residents could also gain valuable insight by following a patient with a fracture throughout their full treatment so they could learn about possible complications.

One final area of questions on the survey showed there is a lack of rural physicians to provide care at athletic events. High school football events are heavily burdened with injuries which are sometimes life threatening, and many times there is no physician coverage for these events; a situation which should be totally unacceptable. We conclude then that all primary care programs should include lectures and curriculum on sports medicine. Conferences on the subject are currently available through the WVAFP.

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Activation by selegiline (Eldepryle®) of REM sleep behavior disorder in parkinsonism

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Abstract

Abnormal sleep-wake organization is frequently seen in idiopathic parkinsonism (PD) and other parkinsonism syndromes. A 1993 article in The Annals of Neurology first described the high rate of REM behavior disorder (RBD) in non-demented PD patients (1). In this article, we present the case reports of three non-demented PD patients who manifested RBD while on recommended doses of selegiline (Eldepryle®). None of them had problems severe enough to suggest RBD while they were being treated with varying doses of other dopaminergic agents (carbidopa/L-dopa, pergolide) unaccompanied by selegiline.

First case report

An 81-year-old male had been referred to Parkersburg Neurological Associates because he was experiencing frequent episodes of violent, loud yelling and punching in his sleep. His history revealed that he had been treated for parkinsonism for two years and that recently he had been prescribed selegiline 5 mg once daily.

His polysomnogram showed increased slow wave sleep for his age (17.8%), prolonged REM onset (136.5 minutes), and slightly diminished REM sleep time (17.3%). Video recordings showed punching movements and vocalizations during REM sleep. Both prior to the time he started taking selegiline and after discontinuing it, his violent activity was absent, but in both instances disrupted sleep with vocalizations were present.

Second case report

A 60-year-old male with PD was referred to Parkersburg Neurological Associates after he awakened "fighting and kicking." This patient's history revealed that his physician had recently prescribed selegiline 5 mg bid in addition to his dosage of carbidopa 25 mg/L-dopa 100 mg bid.

Once selegiline was discontinued, he had no further sleep symptoms. His treatment then consisted of prolonged release carbidopa 50 mg/L-dopa 200 mg bid and carbidopa 25 mg/L-dopa 100 mg bid-tid.

His polysomnogram at Parkersburg Neurological Associates after selegiline was discontinued showed a prolonged sleep onset latency (90.5 minutes), decreased slow wave sleep (4.5%), and slightly increased REM sleep (24.9%). During REM sleep, he had increased phasic chin and leg EMG activity with vocalizations and complex arm movements.

Third case report

A 71-year-old female with a complex past history was referred to the Ohio Sleep Medicine Institute for evaluation of early morning awakening. She had been diagnosed with PD two and a half years prior to being referred, and prior to the diagnosis of PD, a polysomnogram at a hospital in Columbus had indicated an absence of muscle atonia and increased motor activity during REM sleep, as well as the presence of RBD.

When she was referred to the Ohio Sleep Medicine Institute, her history showed that she had been taking selegiline 5 mg bid for about four or five months, and during this time she had started having episodes of screaming, crying and striking out at her husband shortly after falling asleep. Her polysomnogram showed shortened REM latencies (56.5, 33.5 minutes), a normal to increased percentage of REM sleep (21.8%, 27.1%), as well as an increased percentage of slow wave sleep time (32.9%, 28.8%).

REM sleep was better sustained on the second night after treatment with carbidopa 25 mg/L-dopa 100 mg four times daily.

Conclusion

These three cases suggest that selegiline may uncover an otherwise subclinical RBD in PD patients, and further validate the observation that RBD may be a frequent accompaniment of PD. In addition, the treatment of these three patients also suggests that treatment with dopaminergic agents is not a necessary precondition for the presence of RBD.

Consideration of the known neuroanatomy and neurochemistry, as well as neuropharmacology of treatment of both PD and RBD does not suggest a clear explanation of these observations. The mechanism by which this occurs is not likely to be enhanced dopaminergic activity alone. The role of glutamate receptors, which occupy central positions in the neural circuits involved in PD as well as the pontine and medullary areas implicated in RBD, is also not clear.

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A fundamental change

There can be no question that a fundamental change is being forced on the physician-patient relationship -- a change that is not for the better for either party.

Perhaps as long as there have been healers and those in need of healing, physicians have been the agents of those coming to them. In the distant past, it may have been the forces of magic, the spirits or the gods with whom we dealt for our supplicants. In a more recent era, with increasing knowledge, sophistication and technology, it has been bacteria, injury, chemistry and physiology with which we have battled as defendants and representatives of our patients. With such a relationship firmly understood and accepted on both sides, a comfortable feeling of trust and cooperation prevailed between us as physicians and our patients.

Under the aegis of HMOs and "managed care," that comfortable feeling of trust and cooperation is rapidly dissipating and, in many areas with dominant HMOs, is quite frankly gone. In the words of one practitioner, "Medicine used to be fun. I would feel great when I saw a really sick patient and made a difficult diagnosis. Now, six weeks later I can expect a letter from the HMO announcing a sanction for keeping that patient in the hospital too long. If I don't make the diagnosis, I can expect a letter from a plaintiff's attorney asking for the records."

There are some doctors who, in good conscience, continue to adjust, to rationalize, and to integrate the new system of responsibility to an insurance company's fund of money rather than to their patient. They will argue that if the fund of money is dissipated, no one will get any care. Thus, they become saviors of medical care for everyone by just a bit of economy here and there.

Another argument is that there are cheaters among doctors who run up large medical bills primarily for their own benefit rather than for the benefit of their patients, which requires the good offices of case managers. It is unfortunately true that we have such doctors, but the solution to such a problem hardly requires the punishment of all doctors and, along with them, their patients -- the ultimate suffers in any managed care plan.

There can be little question that the physician supporters of managed care are, in general, very responsible people. Perhaps they might be termed grandiose in their sense of responsibility. They assume that theirs is the exclusive ownership of medical responsibility and all others are perforce irresponsible. Truth, honor and fairness are not so onesided in their allegiance.

To illustrate just one hidden danger of managed care, try to divorce yourself of every sense or vestige of responsibility, ethics, morals and scruples. Picture yourself as a sociopath. Then, picture yourself as the physician-in-charge or medical director of an HMO or managed care plan. Knowing what you do about Medicine and how the system works, how difficult might it be for you to reduce your employer's costs 10 percent, 15 percent or any given amount? There are physician sociopaths about and the pressure of increasing competition between various managed care plans makes the services of such increasingly attractive.

There surely is a fundamental change occurring in the relationship between physicians and patients. Physicians with a sense of responsibility who are possessed of honor, integrity and a code of ethics are being squeezed between these and the necessity of providing for their family's needs. Physicians sense the change and the danger -- patients apparently do not. They will when they become ill under a managed care plan.

— Stephen D. Ward, M.D.

Our Readers Speak

Endoscopy recommendations somewhat inappropriate

I enjoyed the recent article by Drs. Lehmann and Elitsur on coins in the upper GI tract of children. The article was well written and brought up many salient points concerning the treatment of foreign bodies of the esophagus. I thought the emphasis on watchful waiting to be particularly valuable since a great many coins and other foreign bodies will of course pass through the entire GI tract, particularly if they have reached the stomach.

I have some concern, however, about the referral recommendations the authors discussed on extraction of coins from the esophagus. They mention foley catheter extraction under fluoroscopy (performed by a radiologist), direct rigid endoscopy (performed by an ENT specialist), or flexible endoscopy (performed by a gastroenterologist). Additionally, they comment that rigid endoscopy is limited to foreign bodies lodged in oral pharynx or proximal esophagus, and that flexible endoscopy is a safer procedure than rigid esophogoscopy.

In my training as a general surgeon, I had experience with all three methods of removing coins from the esophagus. The training of the general surgeon involves the use of both the rigid esophagoscope and the flexible endoscope. As the authors in this article point out, knowledge in the use of both a rigid endoscope and a flexible endoscope is often necessary to remove foreign bodies from the esophagus.

I, therefore, maintain that the recommendations of the authors that a rigid endoscopy be performed by an otolaryngologist and that a flexible endoscopy be performed by a gastroenterologist are somewhat inappropriate, since a well-trained general surgeon is perfectly capable of removing foreign bodies from the esophagus using either of these instruments, as well as the foley catheter technique.

In addition, I also want to comment on the authors' assertion that flexible endoscopy is safer than rigid endoscopy. Obviously, the complication rate of any technique is dependent upon the skill and training of the physician performing the procedure, but I believe that there is no question that the number of esophageal perforations occurring during flexible endoscopy far exceeds those that occur during rigid endoscopies.

Thank you for your consideration of these comments.

Paul W. Burke, M.D., F.A.C.S.
Parkersburg

Other specialists capable of removing foreign bodies

In regards to the article *"Keep the change, Doc!: Coins in the upper GI tract of children"* which appeared in the January issue, I would like to congratulate the authors on a well written review of the management of foreign bodies in the upper GI tract of children. However, I would like to rectify the misconception that was brought forth in the article that ENTs and pediatric gastroenterologists are the only physicians who remove foreign bodies from children. General and pediatric surgeons as well as adult gastroenterologists, have been removing foreign bodies with both rigid and flexible scopes for many years.

During most of the time when the study in the article was being conducted (1984-1991), I was a member of the Department of Surgery at the Marshall University School of Medicine. As faculty members, I and a former pediatric surgeon removed a large number of the foreign bodies in children that were seen by the MU School of Medicine during these years. As a result, I would like to bring to the attention of the readers the fact that there are many competent general surgeons and adult gastroenterologists in rural and urban West Virginia (many of whom I know personally) who are capable of removing foreign bodies.

General surgeons and gastroenterologists are generally located in smaller communities than ENT surgeons and pediatric gastroenterologists. Depending on the experience of the physician, a child with a foreign body may be able to have the foreign body removed without having to travel a long distance. If the local general surgeon or gastroenterologist is uncomfortable with attempting to remove the foreign body due to inexperience or anesthesia support, he/she can refer the patient to a center where the physicians (pediatric gastroenterologists, general or pediatric surgeons or ENT surgeons) are comfortable with the management of foreign bodies.

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Special Correspondence

Stephen D. Ward, M.D., Editor
West Virginia Medical Journal
c/o West Virginia State Medical Association
4307 MacCorkle Avenue, S.E.
Charleston, WV 25304

Dear Dr. Ward,

I wish to remind the readership of the *West Virginia Medical Journal* about the importance of questioning our adolescent patients regarding their use of alcohol, and counseling them about the potential ill effects of this frequently abused substance.

A recent study of alcohol and drug use by American students has shown consistently that alcohol is the most often used and abused drug by children and adolescents. This study was published in the March 1995 issue of *Pediatrics* in an article entitled *"Alcohol Use and Abuse; A Pediatric Concern."*

In 1992, 88% of American high school seniors reported that they tried alcohol at least once, compared with only 82% of 10th graders and 69% of 8th graders. With regard to recent use of alcohol, 51% of 12th graders, 40% of 10th graders, and 26% of 8th graders had at least one drink within the last month. In the most staggering statistic of all, 1 in 30 high school seniors admitted to consuming alcoholic beverages daily.

A family history of alcoholism often predisposes children to problem drinking as well. Sons of alcoholic men have a 25% greater risk of becoming alcoholics themselves. Daughters of alcoholics are also at an increased risk for alcoholism and are more likely to marry alcoholic men, thereby continuing the cycle of family problems with alcohol.

We must all be mindful of the hazards of alcohol use among our adolescent patients, including unintentional injuries, suicides, and homicides which account for more than 80% of adolescent deaths. The number one cause of death among American teenagers ages 15 to 24 is alcohol-related motor vehicle injuries. Since a child's initial use of alcohol frequently occurs before or during adolescence, we must make a habit of asking our patients whether they have experimented with alcohol. A retrospective report on alcohol use by students showed 11% had their first drink by the 6th grade, 38% by the 8th grade, and 60% by the 9th grade.

By asking the appropriate questions, providing the proper counseling and warning them of the ill effects of alcohol, we may prevent our younger patients from serious illness or injury. I encourage all members of the WVSMA who come into contact with teens in their practice, to be aware that these patients may be drinking and that we have an obligation to teach them the consequences of this action. The American Academy of Pediatrics certainly supports the involvement of health care professionals in educating our patients and their families about alcohol.

Sincerely yours,

Norman D. Ferrari III, M.D.
Associate Professor of Pediatrics
Chief of General Pediatrics
and Adolescent Medicine
West Virginia University School of Medicine
Morgantown

At Annual Meeting

Medicine's changing environment in health care reform topic of AMA president's speech

Lonnie R. Bristow, M.D., who will become president of the AMA in June, will deliver his address at the WVSMA's Annual Meeting at The Greenbrier on Saturday, August 19 at 9 a.m. during the Second Session of the WVSMA House of Delegates. Dr. Bristow's presentation will be devoted to the subject of medicine's changing environment due to health care reform.

An internist from San Pablo, Calif., Dr. Bristow was first elected to the AMA Board of Trustees in 1985. Since 1990, he has been a member of the Executive Committee, serving as vice chair from 1992-93; as chair from 1993-94; and as president-elect since June. Dr. Bristow has represented the AMA as a commissioner to the Joint Commission on Accreditation of Healthcare Organizations, as well as served as the secretary-treasurer and president of the AMA Education and Research Foundation during his career.

Dr. Bristow's professional service has been diverse as illustrated by his appointment to serve on the Institute of Medicine's Committee on the Effects of Medical Professional Liability of the Delivery of Maternal and Child Health Care from 1987-89, his appointment by the Surgeon General to serve on the Federal Interagency Committee on Smoking and Health in 1988, and his appointment by the secretary of Health and Human Services to serve on both the CDC's Control's HIV Prevention Advisory Committee and the 1989 Quadrennial Advisory Council on Social Security.

Bristow

Long active in organized medicine, Dr. Bristow has held positions as chair of the Section on Internal Medicine of the California Medical Association, as president of the California Society of Internal Medicine, and as president of the American Society of Internal Medicine. In 1977, Dr. Bristow was honored by his election to membership in the Institute of Medicine of the National Academy of Sciences. He is a diplomate of the American Board of Internal Medicine and a fellow of the American College of Physicians.

A graduate of the New York University College of Medicine, Dr. Bristow completed his internship in 1958 at San Francisco City and County Hospital. He served his residency in internal medicine at U.S.V.A. Hospital, San Francisco; Francis Delafield Hospital (Columbia University Service), New York City; and U.S.V.A. Hospital, Bronx, N.Y. In 1981, he completed an additional residency in occupational medicine at the University of California School of Medicine in San Francisco.

In addition to his speech, Dr. Bristow, along with several other visting state presidents, will participate in the two Lunch & Learn sessions that are scheduled for Thursday, August 17 and Friday, August 18.

Please turn to page 91 for a registration form for this year's meeting or phone the WVSMA at (304) 925-0342.

Cajun musician to entertain at Kate's Mountain

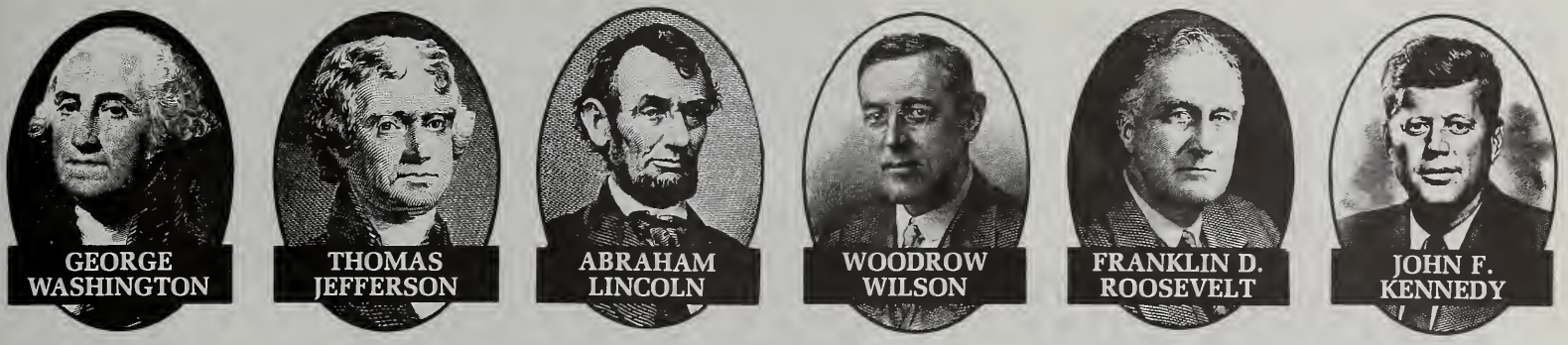
This year's WVSMA Annual Meeting will feature an evening of entertainment on Friday, August 18 with Cajun musician Waylon Thibodeaux at Kate's Mountain on the grounds of The Greenbrier. A buffet dinner will be served.

Thibodeaux is a French-speaking Cajun who performs a variety of Louisiana, Cajun and Zydeco music. Known as Louisiana's Rockin' Fiddler, Thibodeaux began playing professionally at age 13. He has performed with nationally and internationally renowned musicians and groups such as Tony Orlando, Jo-El Sonnier, Jimmy C. Newman, BeauSoleil and Evangeline, and is a artist with Mardi Gras Records. In addition to playing at festivals and special events in the U.S. and Canada, Thibodeaux is a popular act at La Strada's Nightclub in New Orleans.

The cost for the evening is $100 a couple or $50 for a single guest.

To register for the WVSMA Annual Meeting and this event, turn to page 91 or phone the WVSMA at (304) 925-0342.

Thibodeaux



Health problems of six U.S. presidents subject of special lecture by Parkersburg pediatrician

Robert D. Crooks, M.D., a Parkersburg pediatrician who is a noted local historian, will present a special lecture at the WVSMA's Annual Meeting at The Greenbrier on Saturday morning, August 19 during the Second Session of the WVSMA's House of Delegates. His lecture will be entitled *"The Health Problems of Our Presidents"* and will focus on the medical histories of Presidents George Washington, Thomas Jefferson, Abraham Lincoln, Woodrow Wilson, Franklin D. Roosevelt, and John F. Kennedy.

Dr. Crooks is a Parkersburg native who received his A.B. degree from Miami University in Oxford, Ohio, in 1944, and his medical degree from the University of Cincinnati in 1947. He interned at the Medical College of Virginia, where he also completed his residency in pediatrics in 1950.

Following his residency, Dr. Crooks began working as a ship surgeon on two of the Grace Line steamships, the St. Louisa and the St. Paula. He then opened a pediatric practice in Franklin, Va., and worked there until he returned to Parkersburg, where he practiced until his retirement in 1993.

Crooks

During his career, Dr. Crooks was on the staffs of Camden Clark Memorial Hospital and St. Joseph's Hospital, where he served as president of the medical staff. He was vice chairman of the West Virginia Chapter of the American Academy of Pediatrics for two terms and was also a president of the Parkersburg Academy of Medicine.

Dr. Crooks has had a lifelong interest in history and is a charter member of the Wood County Historic Landmarks Commission and a member of the West Virginia Commission on Archives and History. Since he retired, Dr. Crooks has devoted himself to lecturing and writing about topics pertaining to medical history and pediatrics. An award-winning artist, Dr. Crooks began painting in 1960 and has become known for his oil paintings of local historic inns, schools and houses.

Dr. Crooks is a diplomate of the American Board of Pediatrics and a fellow of the American Academy of Pediatrics. He has been a member of the WVSMA since 1953.

Dr. Crooks and his wife, Gloria, are the parents of four children.

Don't Delay . . . Register Today!!!

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Turn to Page 91 or phone the WVSMA at (304) 925-0342

ACCME appoints full-time director

The Accreditation Council for Continuing Medical Education has announced the appointment of Murray L. Kopelow, M.D., as its first full-time director.

Dr. Kopelow is a graduate of the University of Manitoba, a fellow of the Royal College of Physicians and Surgeons of Canada, and a specialist in pediatrics. In addition to his pediatric practice, Dr. Kopelow has been an associate professor of pediatrics and the associate dean for CME at the University of Manitoba.

Legislative Reception

WVSMA President Dr. Dennis Burton and his wife, Kathi, visit with Delegate Brian Gallagher, Delegate Jon Amores, WVSMA Senior Councilor at Large Dr. Constantino Amores and Sonia Daugherty - Chambers of the PEIA.

House Speaker Chuck Chambers chats with Delegates Bruce Petersen, John Overington and Clinton Nichols about their agendas for the session.

Delegates Emily Yeager (left) and Margarette Leach (center) discuss legislative issues with Dr. Lee Neilan of Charleston.

WVSMA President-Elect Dr. James Helsley (third from left) talks with Delegate Charles Trump and Senators Tom Scott and Mike Ross about pending legislation.

At the Legislative Briefing conducted prior to the Legislative Reception, WVSMA Director of Government Relations Winnie Morano, WVSMA Legislative Committee Chairman Dr. Tom Sporck, and WVSMA Executive Director George Rider update members and guests on proposals endorsed by the WVSMA.

National rural health conference set

The National Rural Health Association will hold its 18th annual national conference entitled "Rural Health - - Harnessing the Winds of Change," from May 17-20 in Atlanta.

Designed to focus on helping rural health care providers and systems deal with the changing trends in rural health care brought about by the national health reform debate, this conference will also explore changes in health care to benefit not only providers and health care professionals, but to develop future rural health models.

To receive registration information, contact the NRHA National Service Center, One West Armour Blvd., Suite 301, Kansas City, Mo. 64111, (816) 756-3140.

WVU Department of Ophthalmology plans two meetings

The Department of Opthalmology at the West Virginia University School of Medicine will present its Sixth Annual Ophthalmology Alumni Weekend from May 19-20, and its Sixteenth Annual Clinical Ophthalmology Conference from October 6-7.

This first event will be presented at the WVU School of Medicine and will feature Dr. George L. Spaeth as the Susruta Lecturer and Dr. V. K. Raju as as the Pangilianan Lecturer. The October conference will take place at Lakeview Resort & Conference Center, and will feature scientific sessions, exhibits and special courses for ophthalmic technical and office staff.

For further information, contact Pat Schumann at (304) 293-3757.

May 2 date for SMA live teleconference

"The Brain at Risk: Preventing, Diagnosing and Managing Stroke" is the title of a live, interactive satellite video teleconference being offered by the Southern Medical Association free of charge on May 2.

This teleconference will be broadcast via satellite on C-Band and KU-Band, and will feature a formal program that lasts 60 minutes and a 30-minute question and answer session. It is designed to benefit both primary care and specialty physicians, as well as medical students and residents.

To register or obtain more details, call the SMA at 1-800-423-4992.

Nine loss prevention seminars scheduled

The dates and locations for loss prevention seminars presented by Medical Assurance of West Virginia, Inc. are listed below. For more details or to register, please phone Chuck Ellzey or Steve Brown at (304) 346-8228 or 1-800-331-6298.

Thursday, April 27	**6 p.m.**	**The Stratford, Wheeling**
Friday, April 28	**11 a.m.**	**J.T.'s Restaurant, Morgantown**
Saturday, April 29	**8:30 a.m.**	**Days Inn, Clarksburg/Bridgeport**
Saturday, May 20	**8:30 a.m.**	**Holiday Inn, Martinsburg**
Thursday, June 22	**11 a.m.**	**Marriott, Charleston**
Friday, June 23	**11 a.m.**	**Beckley Hotel, Beckley**
Saturday, June 24	**8:30 a.m.**	**Holiday Inn, Bluefield**
Thursday, July 13	**6 p.m.**	**Blennerhasset, Parkersburg**
Saturday, July 15	**8:30 a.m.**	**Radisson Hotel, Huntington**

Book-based CME offered by APA

The American Psychiatric Association, in collaboration with the American Psychiatric Press, Inc., has launced a unique series of textbook-based CME conferences.

These CME sessions are scheduled from June 30 through July 2 in San Francisco, and from in Washington, D.C. Participants will be offered 15 hours of Category 1 CME credit.

Phone the APA at (202-682-6145 for more details.

Depression: Treat it. Defeat it.

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

Charleston Area Medical Center - Charleston

April 20
(Teleconference) "Clinical Approach to Childhood Obesity"

April 26
"Childbirth Educator's Day"

May 4
(Teleconference) "Pre-term Labor"

May 8-9
"Pediatric Advanced Life Support Provider Course" (Advance Registration Required)

May 18
"5th Annual Issues in Perinatal Health Care"

May 18
(Teleconference) "Home Care Needs of the NICU Graduate"

May 18-19
"Trauma Nursing Course"

Huntington Medical Community Foundation - Huntington

April 11
"Newborn Surgical Emergencies," Bonnie L. Beaver, M.D., Logan General Hospital, Logan, noon

April 12
"Pediatric Transport and Stabilization," J. Michael Waldeck, M.D., Tug Valley Medical Society, The Brass Tree Restaurant, Williamson, 6:30 p.m.

April 25
"Newborn Surgical Emergencies," Bonnie L. Beaver, M.D., Paul B. Hall Regional Medical Center, Paintsville, Ky., 6 p.m.

April 25
"Developing Critical Pathways," Valerie Hopkins, R.N., M.S.N., C.P.H.Q., South Williamson Appalachian Regional Hospital, South Williamson, Ky., 6:30 p.m.

May 16
"Evaluation and Treatment of Chronic Back Pain," Hossein Sakhai, M.D., Brass Tree Restaurant, Williamson, 6:30 p.m.

May 18
"Tumors of the Lung," Jeffrey George, M.D., Pleasant Valley Hospital, Point Pleasant, noon

Robert C. Byrd Health Sciences Center of WVU - Morgantown

April 13
"Glaucoma Day" (sponsored by the WVU Dept. of Ophthalmology), Eurosuites Hotel, Morgantown

April 19
"Ethical Issues in the Care of the Dying" (sponsored by the WVU Center for Health Ethics and Law)

April 21
"Third Annual Stephen C. Rector Visiting Lectureship in Emergency Medicine" (sponsored by WVU Dept. of Emergency Medicine)

April 22
"Cancer Care for the Non-oncologist" (sponsored by Monongalia General Hospital and the WVU Office of CME), Lakeview Resort and Conference Center, Morgantown

April 28-29
"Fine Needle Aspiration for Primary Care" (sponsored by the WVU Dept. of Pathology, WVAAFP, and WV Cytotechnologists Society)

May 12-14
"Anesthesia at The Greenbrier '95" (sponsored by the WVU Department of Anesthesiology and the Virginia and WV State Societies of Anesthesiology), The Greenbrier, White Sulphur Springs

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *Charleston Area Medical Center, Charleston*

Bluefield ☐ Bluefield Regional Medical Center, April 19, noon, TBA*, Sandra Elliott, M.D.

Fairmont ★ Fairmont Clinic, April 19, 1 p.m., "Chronic Pelvic Pain," Thomas Harman, M.D.

Gassaway ☐ Braxton County Memorial Hospital, May 1, 6:30 p.m., "Osteoporosis Treatment in the 90s," Alfred Pfister, M.D.

Grafton ★ Grafton City Hospital, April 27, 1:30 p.m., "Latest Treatment Options for Breast Cancer," Richard Hostetter, M.D.

Man ☐ Man Appalachian Regional Hospital, April 26, 6 p.m., "Suicide Assessment and Prevention," Martin Kommor, M.D.

New Martinsville ★ Wetzel County Hospital, April 13, noon, "Infusaid Implants," Richard Hostetter, M.D.

Parkersburg ★ Camden-Clark Memorial Hospital, April 12, 7:30 a.m., "Fine Needle Aspiration," Carole Boyd, M.D.

★ Camden-Clark Memorial Hospital, April 19, 7:30 a.m., "Gestational Diabetes," Robert Hoeldtke, M.D.

★ Camden-Clark Memorial Hospital, April 26, 7:30 a.m., "Dystonia: What Is It and How Do You Treat It?" Laurie Gutmann, M.D..

☐ Camden-Clark Memorial Hospital, May 11, noon, "Increased Risks of Birth Defects," Norman Duerbeck, M.D.

Point Pleasant ☐ Pleasant Valley Hospital, April 27, noon, "Aortic Dissection," Rakesh Wahi, M.D.

Richwood ☐ Richwood Area Medical Center, April 13, 5:15 p.m., "Osteoporosis Treatment in the 90s," Alfred Pfister, M.D.

☐ Richwood Area Medical Center, May 11, 5:15 p.m., "Cancer Prevention Screening," Arvind Kamthan, M.D.

Ripley ☐ Jackson General Hospital, May 12, 12:30 p.m., "Recent Advances in Anti-Infective Therapy," Christine Teague, Pharm.D.

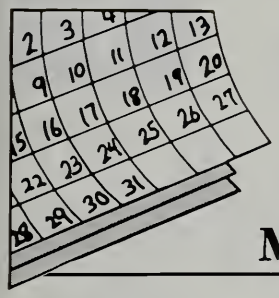
Spencer ☐ Roane General Hospital, April 19, 12:30 p.m., "Management of the Overdose Patient," Greg Rosencrance, M.D.

Waynesburg, Pa. ★ Greene County Memorial Hospital, April 11, 7 p.m., "Bites and Stings" Scott Frame, M.D.

White Sulphur Springs ★ The Greenbrier Clinic, April 24, 4 p.m., "Bone Marrow Transplantation," Joseph Lynch, M.D.

Williamson, Ky. ☐ Williamson Appalachian Regional Hospital, April 27, 5:30 p.m., "Assessment of the High Risk Pregnancy," Norman Duerbeck, M.D.

**TBA - To Be Announced*



Medical Meetings

April

22–Medical Ethics in Pluralistic America: Consensus and Conflict (sponsored by Southern WV Network of Ethics Committees), Beckley

27-30–West Virginia Academy of Ophthalmology's 48th Annual National Spring Meeting, White Sulphur Springs

29–Second Annual Meeting of the American Society of General Surgeons, Boston

28-May 5–American Occupational Health Conference (sponsored by American College of Occupational and Environmental Medicine), Las Vegas

29-May 3–American Radium Society's 1995 Scientific Meeting, Paris

May

3-5–American Academy of Facial Plastic and Reconstructive Surgery, Palm Desert, Calif.

7-11–American College of Obstetricians and Gynecologists, San Francisco

7-13–American Academy of Neurology, Seattle, Wash.

8-9–National Council on Patient Information and Education's 10th National Conference, Washington, D.C.

8-12–American Pediatric Society, San Diego

10-16–American Academy of Environmental Medicine, Houston

12-14–Musculoskeletal Impairment and Disability Evaluation (sponsored by SMA), New Orleans

13-19–American Gastroenterological Association, San Diego

17-19–1995 Annual Conference of the President's Committee on Employment of People with Disabilities, Portland, Ore.

17-20–18th Annual National Conference of the National Rural Health Association, Atlanta

20-25–The American Psychiatric Association's 148th Annual Meeting, Miami

21-23–American Trauma Society, McLean, Va.

31-June 3–American College of Sports Medicine, Minneapolis, Minn.

31-June 3–Diagnostic Imaging Technology Education Conference (sponsored by Diagnostic Imaging Technical Education Center, Inc.), Cleveland

June

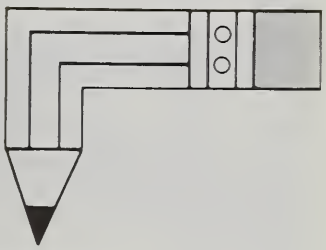
7-9–Third International Symposium on Maritime Health (sponsored by George Washington University), Baltimore

7-9–First Russian-American Breast Cancer Conference (sponsored by National Cancer Institute), Saratov, Russia

8-10–Geriatric Medicine: An Update on Diagnosis and Management (sponsored by SMA), San Antonio

For More Information . . .
Contact the Journal at (304) 925-0342.

Poetry Corner



If You Don't Watch Out!

Be sure to pay your income tax,
No need to weep and pout,
'Cause the I.R.S. will get you
If you don't watch out!

Avoid investment councilors
And all the stocks they tout,
'Cause the market will get you
If you don't watch out!

Don't ever start a legal war,
It may turn out a rout,
And the lawyers will get you
If you don't watch out!

Don't cross the street in traffic
Or a motorist may shout,
"I'm going to hit your butt next time
If you don't watch out!"

Be careful that you don't inhale
When cigarette smoke's about,
Or lung cancer may get you
If you don't watch out!

Run and swim and exercise
And never get too stout
Or a heart attack may get you
If you don't watch out!

Avoid the hot pastrami
And spare ribs with sauerkraut,
'Cause cholesterol will get you
If you don't watch out!

Remember to put your sunscreen on,
Don't ever go without,
Or skin cancer will get you
If you don't watch out!

Practice only the safest sex,
Don't ever leave a doubt
Or the AIDS virus may get you
If you don't watch out!

Or ignore all of these warnings,
Don't be too smart or clever
'Cause something's gonna get you
Since no one lives forever.

Harold L. Saferstein, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Department of Health & Human Resources

Bureau for Public Health News

This page of material is submitted and paid for by the Bureau for Public Health.

Seven health departments honored for high immunization rates

The Bureau for Public Health has recognized seven county health departments for achieving high immunization rates to protect children from preventable diseases. Grant County Health Department adequately immunized 90% of its children under age two, while Brooke, Braxton, Cabell, Marion, Marshall and Pendleton counties achieved immunization rates of 80% for two-year-olds in 1994.

According to the U.S. Centers for Disease Control and Prevention, most of all immunizations should be given before the age of two to insure adequate protection. Infants and toddlers should receive several series of shots for diphtheria, tetanus, pertussis (whooping cough), polio, measles, mumps and rubella. Unfortunately, only about half of the children in West Virginia receive all of the needed vaccines before they are two years old. The 1996 state and national goal is to have 90% of all children properly immunized by their second birthday.

The Bureau for Public Health's Immunization Program recently launched its Vaccine for Children program, as part of the nationwide effort to reduce and eliminate barriers to immunization. Activities planned as part of the project include promoting public health clinic services, extending clinic hours and offering more satellite clinic sites to allow for convenience for working parents, gaining community support for immunization activities, and providing private physicians with free vaccine for eligible children. West Virginia law also now mandates that all health insurance policies cover the cost of childhood immunizations.

For more details on the childhood vaccine schedule or on needed statewide activities to improve preschool immunization levels, call (304) 558-2188 or 1-800-642-3634.

Bureau to join CDC data network

The Bureau for Public Health has received a grant from the U.S. Centers for Disease Control and Prevention (CDC) to initiate a communications and training network for public health agencies around the state.

The grant will be used to link West Virginia to the CDC's Information Network for Public Health Officials (INPHO). This network utilizes state-of-the-art telecommunications to bring together public health practitioners throughout the country to exchange information with each other, with the CDC, and with colleagues at the state and local levels across the nation and the world. In addition to keeping public health providers up-to-date on information about such areas as disease outbreak and control, this network will also provide information on the availability of vaccines and other medications, as well as on community health assessment data and various other public health concerns.

The INPHO project also calls for the Bureau to produce a number of live, interactive teleconferences that would be viewed across the state. These productions would increase the training capacity of state and local public health professionals by saving travel time and costs associated with attending classroom-type seminars. It also allows for an improved and immediate exchange of information among the participants who may not otherwise be in a position to link up with their colleagues.

The three-year grant provides $500,000 in the first year, with additional funds of as much as $1 million dollars in each of the next two years. West Virginia is one of only 12 states to be included in the initial funding of the project.

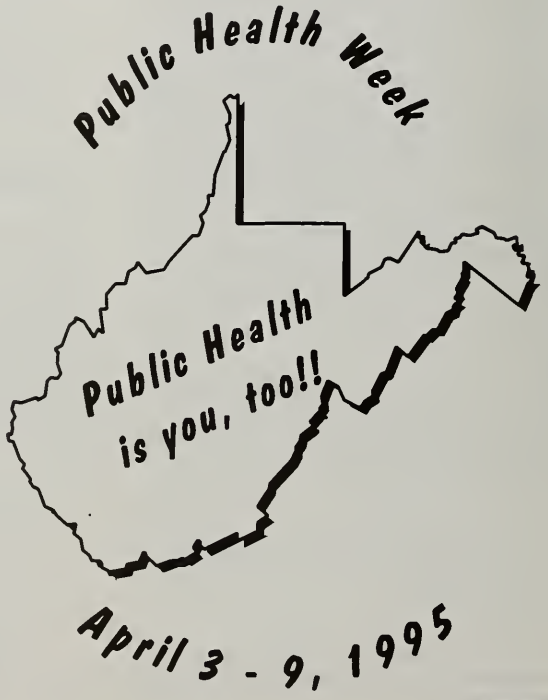
New primary care centers funded

Thirteen new primary care centers are underway in underserved areas of the state to provide health care, health education and prevention services.

The recent funding of $700,000 has been awarded as the latest part of the "New Start" Comprehensive Primary Care Center Project Governor Gaston Caperton requested of the Legislature. A total of nearly $4 million has been appropriated for the three-year project.

A portion of this year's funding will be used to begin operations of primary care centers in Boone, Braxton, Fayette, McDowell, Pocahontas and Wirt counties. These facilities received funds last year to begin planning their operations. A primary care center in Preston County also received a portion of the new funds to begin its operation. Centers in Clay, Gilmer, Morgan, Preston, Ritchie, Summers and Wyoming counties received part of the new funding to start the planning phase for their new facilities.

All sites should be operating no later then June 1996, bringing the number of non-profit primary care centers in West Virginia to 105.



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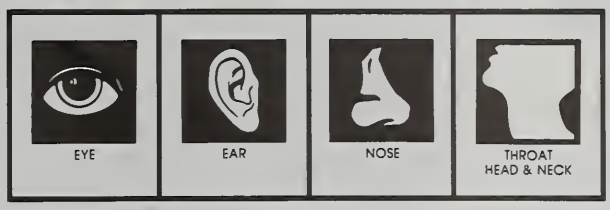

EENT SEMINAR FOR PRIMARY CARE PHYSICIANS 1995 UPDATE

DATE
Saturday, May 20, 1995

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ROBERT C. BYRD HEALTH SCIENCES CENTER

OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

New Department of Medicine chair named

Weinman

Dr. Edward J. Weinman, professor and vice chair of medicine at the University of California School of Medicine at Los Angeles, has been named to chair the Department of Medicine effective July 1.

Dr. Weinman, a specialist in kidney function, is also currently chief of the medical service at the Sepulveda, Calif., VA Medical Center. In his new role at WVU, Dr. Weinman's duties will include an appointment to the medical staff at the VA Medical Center in Clarksburg.

Dr. Weinman is a graduate of Columbia College and the Boston University School of Medicine. He completed postgraduate training at Montefiore Hospital and Medical Center in New York, and at the Yale University School of Medicine.

The principal investigator in a major kidney research project funded jointly by the NIH and the Department of Veterans Affairs, Dr. Weinman has helped identify another protein in the kidney. This protein aids the kidney in regulating the balance between water and minerals in the body; it may also be involved in the regulation of the body's acid balance.

The identification of this protein may assist physicians in understanding abnormalities in patients with kidney diseases, diabetes mellitus and high blood pressure. All three of these disorders are prevalent among the populations served by WVU and the Clarksburg VA Medical Center.

The chair of medicine post has been vacant since Dr. Theodore Kotchen resigned in 1992. Dr. Rashida Khakoo, chief of the Section of Infectious Diseases, has been the interim chair.

Stullken lectureship dedicated at WVU

Stullken

Dr. Edward H. Stullken, professor and chair of anesthesiology, has resigned from all administrative responsibilities at WVU Hospitals and University Health Associates, and has taken a medical leave of absence from his faculty position in the School of Medicine.

The School of Medicine presented a CME conference in Dr. Stullken's honor on March 17. At this event, the "Edward H. Stullken Jr. Lectureship: New Directions in Medicine" was dedicated in recognition of Dr. Stullken's key role in fostering change and in shepherding WVU through the transition to managed care. A permanently endowed fund is being established for this effort.

WVU first to acquire new imaging system

Ruby Memorial Hospital is the first hospital in the country to work with General Electric Medical to develop an electronic medical imaging system. This system allows doctors to diagnose and treat patients more rapidly.

Dan Shock, administrative director of radiology and radiation therapy at Ruby Memorial, said that the system is a network of computers than can store and retrieve digital X-rays images. The system will also allow a digital X-ray image to be viewed on a computer screen at workstations in the critical care units, the Emergency and Radiology Departments.

"Physicians throughout the hospital will be able to go to a workstation and access X-ray images," says Dr. Mathis Frick, chair of the Department of Radiology.

According to Shock, the system will accept medical images produced on both GE and non-GE diagnostic imaging equipment.

Frame appointed ED medical director

Frame

Dr. Scott Frame, assistant professor of of emergency medicine, is the new medical director of the Emergency Department at Ruby Memorial Hospital. Previously, he was director of ED operations.

In this position, Dr. Frame will be the contact person regarding all medical issues involving practice of medicine in the ED.

Four physicians listed as "Best Doctors"

Three WVU faculty physicians and one alumnus are included in *Town and Country* magazine's February issue on a list of the top medical specialists in the U.S. compiled from nominations by doctors, interns and residents.

Dr. Donald Lamm, professor and chair in the Department of Urology, is listed as one of the top doctors treating prostrate cancer patients, and was noted for his work in intravesical immunotherapy.

Dr. Gordon Murray, professor and chair of surgery, and Dr. Ronald Hill, an associate professor of cardiothoracic surgery, were both noted for their expertise in treating heart disease.

The article also listed AIDS specialist Dr. Philip Hopewell, a 1965 WVU graduate. Dr. Hopewell is a professor of medicine at the University of California School of Medicine in San Francisco, and is also chief of the division of pulmonary and critical care medicine and associate chief of medical services at San Franciso General Hospital.

Gutmann completes term with ABPN

Dr. Ludwig Gutmann, professor and chair of neurology, has completed an eight-year term as vice president of the American Board of Psychiatry and Neurology.

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Marshall University School of Medicine

MARSHALL UNIVERSITY

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

Specialists in pediatric, reconstructive surgery join MU faculty

Beaver

Faltaous

Bonnie Beaver, M.D., a pediatric surgeon and child trauma specialist, and Adel Faltaous, M.D., a plastic and reconstructive surgeon, have joined the School of Medicine faculty.

Dr. Beaver was previously on the faculty at Ohio State University and served as director of pediatric trauma services and surgical critical care for the Children's Hospital of Columbus. She also has been on the faculties of the University of Maryland and Johns Hopkins University.

Dr. Beaver completed her residency training and a research fellowship at Ohio State, where she received the Housestaff Outstanding Teacher Award four times. She left Ohio State to complete a residency in pediatric surgery at Johns Hopkins and the University of Maryland. Dr. Beaver then did further postdoctoral work at the Johns Hopkins School of Hygiene and Public Health.

The author or co-author of nine chapters in medical books, Dr. Beaver has had more than two dozen articles published, and has lectured nationwide. She serves on the Trauma Committee of the American Pediatric Surgical Association and the Publications Committee of the American Academy of Pediatrics Surgical Section.

Dr. Beaver is a fellow of the American College of Surgeons, the American Academy of Pediatrics Surgical Section, and the American Association for the Surgery of Trauma.

Dr. Faltaous, who specializes in hand surgery, microsurgery and breast reconstruction, came to Marshall from the University of Virginia, where he completed an accredited fellowship in hand surgery and microsurgery. During residency training, Dr. Faltaous served as chief resident in plastic and reconstructive surgery at the Cleveland Clinic Foundation and as chief resident in general surgery at the Albert Einstein College of Medicine.

While in Virginia, Dr. Faltaous invented a new technique for tendon repair. At the Cleveland Clinic, he developed the submental artery flap for facial reconstruction.

Dr. Faltaous won the prize for clinical papers from the 1993 annual meeting of Ohio Valley Society for Plastic and Reconstructive Surgery. He has also made presentations to the New York Academy of Medicine, the American Society of Reconstructive Microsurgery, The American Society of Plastic and Reconstructive Surgery, the American Society for Surgery of the Hand, and other medical organizations.

Diabetes Center testing new insulin product

To help people with diabetes reduce long-term medical complications, Marshall's Diabetes Center is testing a product designed to streamline the insulin-taking process.

According to Dr. Bruce Chertow, director of the center, the new product blends long- and short-acting insulin in pre-filled syringes. The mixture reduces the number of insulin injections needed each day to two. Patients set their dosage using a dial on the syringe, making it far easier to measure correct dosages.

"We think users will like this product because it is convenient, accurate and requires fewer sticks," Dr. Chertow said. "It should prove very helpful to people who have vision problems or limited hand movement."

The Marshall project, which began February 1, will try to determine if this product and a communication system tailored to the needs of rural patients will help those patients better control their blood sugar levels.

"Because they tend to live some distance from their doctors, rural diabetic patients cannot as easily call their doctor or drop by the office to ask the nurse a question," Dr. Chertow said. "We think that using the pre-mixed, pre-filled insulin syringes will make taking the shots more routine.

"We also are providing patients in the study with glucometers and modems, which will make it much easier for them to report information on their blood sugar levels to us every two weeks."

Gonzalez-Lavin speaks at meeting in France

Gonzalez-Lavin

Dr. Lorenzo Gonzalez-Lavin discussed and demonstrated heart valve replacement surgery at the *"Second Live Teleconference on Valvular Autografts and Homografts Banking and Surgery,"* which was conducted from February 16-17 in Marseilles, France.

At the meeting, Dr. Gonzalez-Lavin lectured on the pulmonary autograft, then performed the surgery in a sound- and video-equipped operating room from which he could speak with surgeons attending the conference.

Dr. Gonzalez-Lavin joined the Marshall faculty as chief of the section of cardiothoracic surgery in 1989. He is a member of the University Physicians and Surgeons medical group.

A founding member of the International Association for Cardiac Biological Implants, Dr. Gonzalez-Lavin has lectured extensively on the subjects of valve replacement and the treatment of congenital heart disease. He is a member of the Scientific Committee for the Advancement of Cardiac Bioprosthesis.

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Alliance News

Get in the know

How aware are you of the relationship between your county alliance/auxiliary and the WVSMA Alliance and the AMA Alliance? Do you know about the benefits that you and your county alliance/ auxiliary have available, directly or indirectly, from these two organizations? Did you realize that some of these benefits are offered to you even if you aren't a member of either the WVSMAA or AMAA?

Are you aware of what's happening legislatively in these two groups? How about with community health? Do you know about our work with breast cancer screenings and awareness through the SMAA? Are you aware of our ties to the Tobacco Control Coalition and the Family Violence Task Force? Do you know about all the scholarships and research grants that are given by the WVSMAA to students in medical fields?

If you cannot answer yes to all of the questions I have just asked, then I encourage you to start attending the WVSMAA Board of Directors' meetings and the WVSMAA Annual Convention, as well as the AMAA Convention and Confluence. You don't have to be a member of the board or a delegate to these conventions in order to attend - - you just need to show up! These meetings are where the major work of these two organizations is discussed, analyzed and planned - - just as it is at the county level in your own alliance/auxiliary meetings.

From visiting the various alliances/auxiliaries and reading your reports these past months, I've discovered how many of our members aren't participating at the state and national levels. This situation distresses me because Medicine is at a real crossroads and we're all in this together. For us to get the job accomplished in the most expedient manner, we MUST work together with a focused effort, rather than each of us going off in different directions or wasting time "reinventing the wheel."

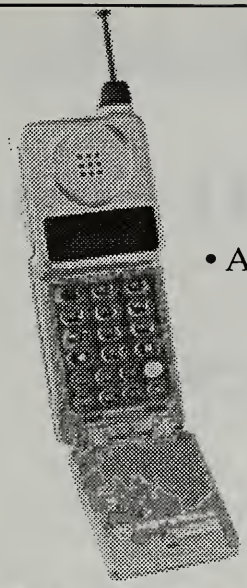
The AMAA and WVSMAA have programs with proven success records, and materials to accomplish them, with little or no expense to you. Both organizations are open to hearing about new projects and new ways to do the old projects, in order that we all can find better ways to accomplish our goals. But you have to get "in the know" in order to be aware about what's available, as well as share your expertise so the rest of us can benefit from it!

The WVSMAA Spring Board meeting will be held at DeCarDe's in Clarksburg on Tuesday, April 25 from 11 a.m. - 4:30 p.m. The cost is $10 to cover coffee time as you arrive and a luncheon at noon (both are lowfat). Please mail your checks to me by April 18. I think you'll be glad you attended!

The AMAA Convention will take place from June 18-21 in Chicago. I will be happy to make you a delegate or alternate if you would like to attend. It is always a very educational experience. In addition, our WVSMAA Convention is scheduled for August 18 - 19 at The Greenbrier. Many of you will be there anyway with your spouses, so please come to our two sessions!

I hope you will take advantage of being a part of as many of these state and national events as possible.

Sue Bryant
WVSMAA President



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New year, new challenges

Over the past three years, the WVSMA Medical Student Section has undergone a complete metamorphosis - - growing from a couple of students meeting over coffee to a much larger, organized group consisting of over 300 members. In addition, in the last year we have also added a new student chapter at the West Virginia School of Osteopathic Medicine in Lewisburg, and seen the largest delegation of students ever from West Virginia attend the AMA Annual Meeting. The former and present leaders of the MSS take great pride in these accomplishments, as well as the fact that the individual campus chapters have been more active than ever before with events such as "Meet the Candidates," MSI orientation lunches, community service projects, and ACLS courses.

Now, with another year underway there are many new challenges. The MSS will take on a new personality as new fourth-year students begin to plan for the Residency Match and the sophomore class moves from the classroom to the bedside. Meanwhile, a whole new flock of MSIs will be buying their dissectors, and the new MSIIs ask the inevitable question, "What's on the boards?"

Even though we are 300+, our rank and file is still LESS THAN HALF of the medical students in West Virginia. Increasing membership will be a major goal during 1995. More than ever before, the WVSMA has been seeking student input. I hope to see more MSS members on WVSMA committees, as well as increase our delegation to Chicago for the AMA Annual Meeting in June, where I hope we can not only provide interesting and useful legislation, but also nominate a candidate for national office.

On the state level, our Executive Council has started planning for the upcoming year. The new Council consists of Melissa Matulis as vice-president, Kristen DeHaven as secretary-treasurer, and two members from each campus as councilors. All MSS members are welcome to attend Council meetings, as are visiting students from other schools. I hope more students will be able to participate this year.

Participation, however, can take many different forms. Simply being a member is ACTIVE participation. In addition, covering call schedules or helping out with school work so other students may attend meetings is a great way to participate. In addition, I would like to encourage everyone to take an interest in medical policy-making (not just politics) in some way. Many students may be blindsided by the efforts of legislators and private-interest groups who are attempting to remodel our health system. If we are uninformed, inactive, complacent, or apathetic, our professional careers and the practice of medicine may be in jeopardy. As students, we have an opportunity to learn, ask questions, give our viewpoints, and even suggest change.

Again, I encourage all MSS members to become more involved this year. If you have questions about the MSS, please feel free to contact me, any of the other Executive Committee members, or Donna Webb, WVSMA membership coordinator, at 925-0342.

Dominic Cottrell, MSIII
WVSMA-MSS President

FAYETTE

WVSMA President Dr. Dennis Burton was the guest speaker for the March meeting. His presentation was entitled *"The Changing Face of Medicine in West Virginia."*

During his speech, Dr. Burton described managed care, especially as it relates to the Medicaid system, and he discussed medical matters under consideration by the West Virginia Legislature.

MCDOWELL

At the society's February meeting, Dr. Chandra Patel's membership was approved.

A donation to the McDowell County Council of Teachers of Mathematics was also discussed. Final decisions on this request, as well as another one from the United Way of McDowell County, were to be made at the next meeting.

MERCER

Dr. Donald Asbury, a board certified allergist, was the guest speaker for the society's February meeting. In his lecture on *"Allergies,"* Dr. Asbury presented a historical background of the work achieved by various investigators in the allergy field, and their diagnostic and therapeutic approaches.

This meeting was well attended and was co-sponsored by Bluefield Regional Medical Center and Allen & Hanburys. An hour of CME credit was offered for Dr. Asbury's lecture.

At the society's next meeting on March 20, the lecture "*Advanced Laparoscopic Surgery*" was presented by Stephen Faulkner, M.D.

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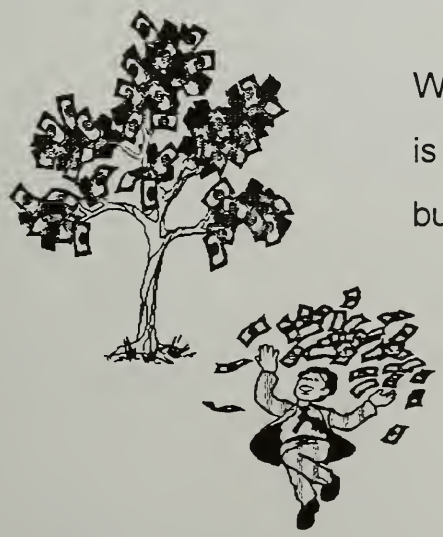

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The following is a list of the physicians and Alliance members who have made WESPAC contributions since January:

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If your county is not represented, please contact your component society president and request someone be appointed.

WESPAC
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Obituaries

James S. Kessel, M.D.

Dr. James S. Kessel, 70, of Evans, died February 27 at his residence after an extended illness.

Dr. Kessel was born in Morgantown, a son of the late Dr. Charles Royal Kessel and Ruby Staats Kessel. He was a graduate of West Virginia University and Jefferson Medical College.

An Army veteran of the Korean War, Dr. Kessel was owner/operator and physician at Kessel's Clinic in Ripley for 44 years. He was a member of the Cottage-Evans Baptist Church.

Surviving are his wife, Mona Ann Kessel; two sons, Dr. James W. Kessel of Charleston and Dr. Steven R. Kessel of Charlotte, N.C.; two daughters, Elizabeth Diane Rhodes of Japan and Deidre Lynn Smith of Washington, D.C.; three stepdaughters, Cassandra Ann Judge, Tamala R. Arthur and Sharon K. Quesenberry, all of Ripley; one brother, Charles Enoch Kessel of Ripley; one sister, Betty Louise McLaughlin of Pittsburgh; and 14 grandchildren.

Memorials are preferred to the Dr. James S. Kessel Scholarship Fund, c/o Marci Henri, treasurer, 122 S. Court St., Ripley, WV 25271.

Lewis H. McConnell, M.D.

Dr. Lewis Harvey McConnell, 52, of Charleston, died March 27 at CAMC, Memorial Division, of cancer.

Dr. McConnell was a graduate of Potomac State College, West Virginia University and the WVU School of Medicine. He interned at Walter Reed Army Medical Center in Washington, D.C., and completed his residency and postgraduate work in allergy and immunology at Milwaukee County General Hospital in Milwaukee, Wis.

An Army veteran, Dr. McConnell was board certified by the American Board of Internal Medicine, the American Board of Allergy and Immunology, the Conjoint Board of the American Board of Pediatrics. He was a member of the First Presbyterian Church.

Surviving: wife, Elizabeth Rhodes McConnell; daughters, Ann McConnell at home, Amy McConnell of Atlanta; sons, David and John, both of Harrisville, Paul of Morgantown; stepson, George Spruce of Charleston; mother, Louise McConnell of Smithburg, sisters, Carol Cottrill of Smithburg, Terry McConnell of Houston, Lou Ann Fatora of Frisco, Colo.; brother, Tom of Denver, Charles of Gaithersburg, Md.; one stepgrandson.

James L. Thompson, M.D.

Dr. James L. Thompson, 88, of Weirton, who was the retired director of medical services at Weirton Steel Corporation, died December 3 at Weirton Medical Center.

Dr. Thompson was born on April 14, 1906, in Binscarth, Manitoba, Canada, and graduated from the University School of Medicine in Manitoba in 1930. He interned at Misericordia Hospital in Winnipeg, Canada, and then completed a residency at Ohio Valley Hospital in Steubenville, Ohio.

In 1933, Dr. Thompson was named assistant chief surgeon of Weirton Steel's Steubenville plant. He became assistant medical services director in 1935, and in 1951 he was appointed director of medical services.

After a 44-year career with Weirton Steel, Dr. Thompson retired on January 1, 1978. Even though he was retired, Dr. Thompson remained as a consultant with the company until April 1989. In his honor, the Weirton Steel Medical Center at Gate 1 was renamed the J. L. Thompson Health Center in 1978.

A member of the building committee for the former Weirton General Hospital, Dr. Thompson was also instrumental in helping design the outpatient and emergency departments at Weirton Medical Center. He was a past president of the Hancock-Brooke Division of the American Cancer Society, the Hancock County Medical Society and the Fort Steuben Academy of Medicine.

In addition to being a member of the WVSMA and the Hancock County Medical Society, Dr. Thompson was a member of the AMA and the MA. He was a fellow of the Industrial Medicine Association, the International College of Surgeons and the American College of Chest Physicians. He was also a certified member of the American Board of Preventive Medicine in Occupational Health.

Surviving are two sons, James of St. Petersburg, Fla., and John of Monkton, Vt.; and two grandsons, Eric and Brian Thompson of Cleveland.

Dr. Thompson was preceded in death by his wife, Elizabeth Graul Thompson; and three brothers and three sisters.

Imelda D. Stevenson, M.D.

Dr. Imelda Deegan Stevenson, 49, of Morgantown, died February 14 at Ruby Memorial Hospital after a long illness.

Dr. Stevenson received a diplomate in nursing degree from the St. Joseph's School of Nursing in Parkersburg in 1966. She was the director of nursing at CAMC, General Division, from 1975 until 1979, and then attended medical school at Marshall University and West Virginia University.

After Dr. Stevenson graduated from the WVU School of Medicine in 1987, she remained at WVU to do an internship in internal medicine and a residency in ophthalmology. She was chief resident in ophthalmology at WVU during her last year, and completed three research projects on eye disease for the annual meeting of the Association for Research in Vision and Ophthalmology in Sarasota, Fla.

A member of the hospital staffs at Monongalia General and Fairmont General, Dr. Stevenson practiced in association with Marion Eye Consultants in Fairmont, and V. K. Raju, Morgantown. She was a clinical assistant professor in the Department of Ophthalmology at WVU and served on the executive council of the WVU Alumni Association.

In addition to being a member of the WVSMA, Dr. Stevenson was a member of the Monongalia County Medical Society, the West Virginia Academy of Ophthalmology and the American Academy of Ophthalmology. Dr. Stevenson was also a member of the Morgantown Lions Club and a sustaining member of the Junior League of Charleston.

Dr. Stevenson is survived by her husband, Dr. James M. Stevenson; two sisters, Alice D. Ulch of Winter Park, Fla., and Mary Jo Martin of Summerville, S.C.; a brother, Joseph M. Deegan of Cross Lanes; seven nieces and nephews; and two nieces/goddaugters, Mary Lynn Ulch of Phoenix, and Theresa Marie Martin of Summerville.

Donations may be made to the Dr. Imelda Deegan Stevenson Scholarship Fund at the WVU School of Medicine and mailed to the WVU Foundation/ Stevenson Fund, Box 9118, Morgantown, WV 26506-9118.

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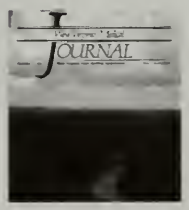
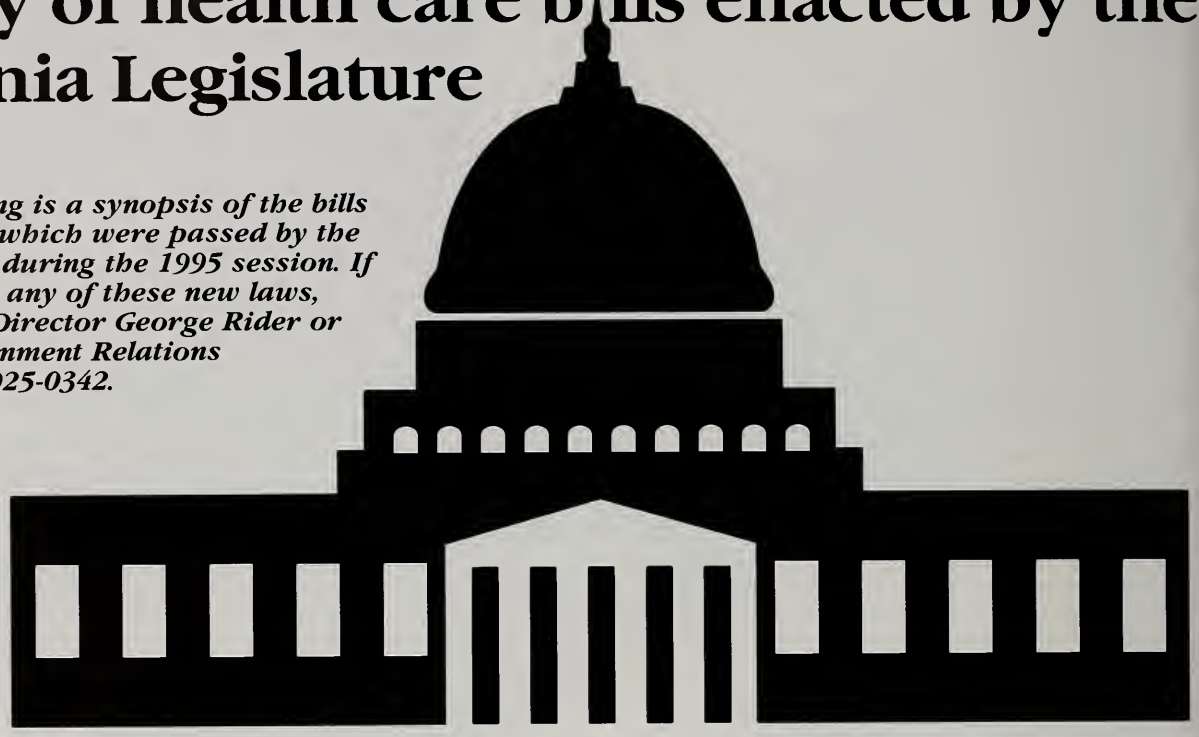


Front Cover

A view of Cheat River from Cooper's Rock State Forest Overlook. Photo courtesy of *Gerald S. Ratliff*, West Virginia Division of Natural Resources.

A summary of health care bills enacted by the West Virginia Legislature

Editor's Note: The following is a synopsis of the bills pertaining to health care which were passed by the West Virginia Legislature during the 1995 session. If you have questions about any of these new laws, contact WVSMA Exective Director George Rider or WVSMA Director of Government Relations Winnie Morano at (304) 925-0342.



House Bills

HB 2033 (*Discharge of Certain Mentally Ill Patients*) Requires the supervising physician to notify the prosecuting attorney no later than 30 days prior to the release of a defendant, if the physician believes the defendant's mental illness may cause jeopardy to himself or others. In addition, the law allows the Department of Health and Human Resources to provide to the Legislature, on or before the first day of the regular session in 1996, a proposed plan for implementing a conditional release or outpatient status program for persons committed to an inpatient mental health facility due to having been judicially determined to be not guilty by reason of insanity.

HB 2276 - Continues the Emergency Medical Services Advisory Council.

HB 2348 - Creates the Board of Respiratory Care and licenses respiratory care practitioners. The board includes seven members - - one lay person, one practicing physician with experience in pulmonary disease, and five people engaged in respiratory care for five years.

HB 2413 - Requires continuing educational requirements for insurance agents who market HMO programs.

HB 2451 - Updates regulations for the practice of pharmacology and establishes certification of pharmacist's assistants, allowing them to dispense prescriptions under the direct supervision of a pharmacist.

HB 2476 - Requires filing a Certificate Of Need application before any new personal care service may be offered or developed in West Virginia.

HB 2491 - Strengthens health insurance laws so that health insurance consumers are treated more fairly and health insurance benefits paid out by health insurers are reasonable in relation to the premium paid by the consumer. This bill raises the loss ratios an insurer must show on individual accident and sickness policies in order to be eligible to receive a premium rate increase; makes individual accident and sickness policies guaranteed renewable; creates rate deviation standards which individual major medical policies must meet; extends the mandatory period during which an employee must be given the opportunity to purchase converted group health insurance coverage after separation from employment; raises the loss ratios which a small group health insurer must show to be eligible to receive a rate increase; and reduces the period during which small employer group insurers may deny coverage of a pre-existing medical condition of the insured.

Additionally, this law also establishes medical savings accounts (MSAs) for individuals wanting to self-insure. It also provides that an individual or employer and/or employee may purchase a high deductible insurance policy, coupled with an MSA of up to $2,000 to be used only for health care expenses. This insurance policy would cover everything over the deductible that typical insurance plans do, while the MSA would be funded to cover smaller medical expenses, such as preventive health care. If an individual does not use up the $2,000 in the MSA for health expenses in a year, the money collects interest and each year another $2,000 is put into the account. This money does not become taxable income unless it is used for purposes other than health care expenses. Once an individual reaches the age of 59 and a half, he/she can take out the money tax free for any use.

HB 2492 ***(Controlled Substances Monitoring Act)***
Requires pharmacists to report to the Board of Pharmacy anyone prescribing Schedule II drugs. This information can be made available to law enforcement officers.

HB 2557 ***(Health Professionals Student Loan Programs)***
Establishes a $10,000 loan program for fourth-year medical students and for nurse practitioners, nurse mid-wives, physician assistants, or other disciplines who sign an agreement to practice for at least two years in an underserved area of West Virginia.

HB 2559 - Allows for the transfer of all disproportionate share hospital funds in the West Virginia Rehabilitation Center Special Account to the Medical Services Trust Fund.

HB 2578 - Allows the Department of Health and Human Resources to recover the estates of Medicaid recipients who died at age 55 or older, for the total amount of medical assistance provided by Medicaid.

HB 2619 - Allows the state Insurance Commissioner to regulate HMOs which provide coverage in West Virginia. Requires HMOs to provide information about what their plans will cover; any exclusions or limitations; the total amount of payment and co-payments, if any, is expected, and the HMOs method of resolving enrollee grievances. This bill precludes non-participating physicians from billing any HMO beneficiary for the difference the HMO pays for a service and what is the non-participating physician's usual and customary charge.

HB 2722 - Exempts hospitals with a three-year accreditation from a periodic license inspection, while requiring them to perform annual self-evaluations based on the most recent Accreditation Manual for Hospitals.

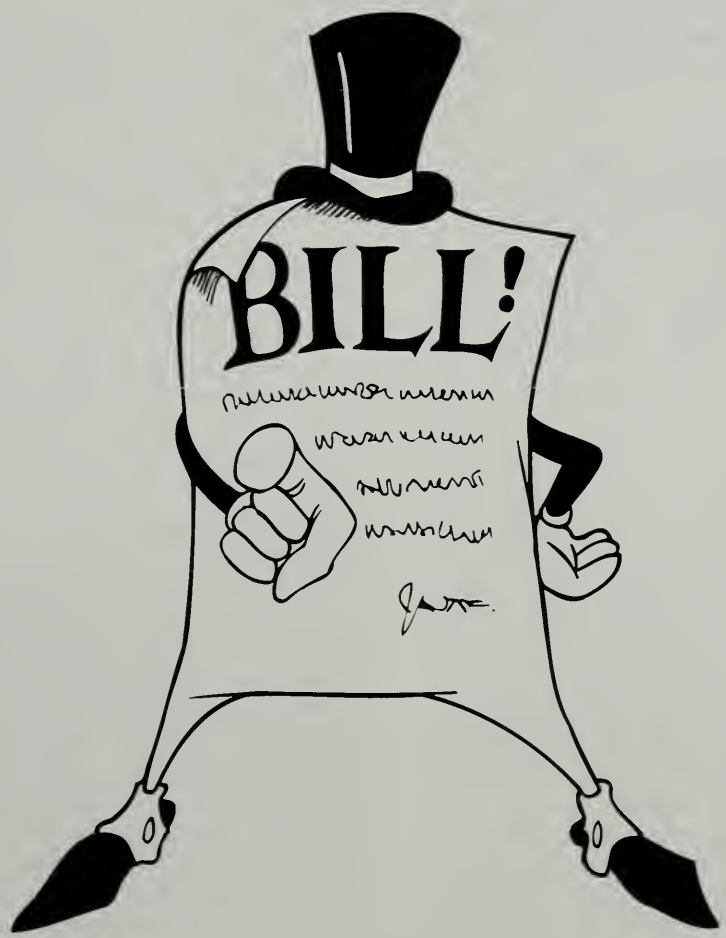
Senate Bills

SB 161 - Purpose is to continue two highly acclaimed programs on rural health care (Kellogg Program and the Rural Health Initiative) as one program.

SB 252 - Creates DNA Database and Databank in West Virginia. Allows the Division of Public Safety to establish and administer a DNA identification system, and to inspect DNA forensic laboratories in the state to make sure they are in compliance with federal and state laws.

SB 442 - Requires any health care provider who examines or renders medical treatment to a person suffering from injuries caused by a burn from fire or chemicals, to report it to the state fire marshal if arson is suspected to be the cause of the injury.

SB 563 - Creates the Legislative Oversight Commission on Health and Human Resources Accountability made up of six members of the Senate and six members of the House of Delegates. They will carry out a continuing investigation, study and review of the practices, policies and procedures of the health care and social service agencies; make continuing investigation, study and review all matters related to health and social policy, and review program development by the various agencies of DHHR. The commission will also produce indepth studies and reviews of the Medicaid program, specifically to ensure that maximum effectiveness and efficiency are used in the program.



Hospice: From grassroots to the mainstream

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Abstract

Hospice care was created 20 years ago in the United States so terminally-ill patients would have an alternative to spending months in an institution or hospital before their death. When this grassroots movement began in West Virginia in 1980, most of the care was provided by volunteers. Today, with increased physician involvement, hospice has been accepted into mainstream medicine and now offers a comprehensive range of services for terminally ill patients and their families. Nationally, there are now over 2,000 hospice programs, and in West Virginia there are 23 hospices providing care in 48 counties. Ongoing physician involvement is essential to ensure that hospices provide a high quality of care and continue to operate effectively in West Virginia. This article is designed to increase understanding about hospice services, admission guidelines and the role of the attending physician in order to improve the understanding of what has become one of the best options for care for the terminally-ill patient.

Introduction

Hospices in West Virginia may be independent community-based programs, hospital-based, or affiliated with home health agencies. Approximately two-thirds of all hospices are officially certified by Medicare, which means that they offer a specific range of services and have to meet certain standards (1). If the program is not Medicare certified, it is important to ask questions about the available services.

To receive Medicare certification a hospice must provide:

(1) Staffing on a 24-hour basis;
(2) Medical and nursing care;
(3) Home health aide services;
(4) Access to inpatient care;
(5) Social work services;
(6) Counseling and bereavement support;
(7) Medications, medical supplies, and durable medical equipment; and
(8) Physical, occupational and speech therapy.

Hospice care utilizes an interdisciplinary team approach to care for both the patient and his/her family. The care is physician directed, but it is coordinated and managed by a hospice nurse on a day-to-day basis. Hospice nurses receive specialized training and many are now certified. The National Board for Certification of Hospice Nurses was established in 1993, and since then hospice nursing has been officially recognized as a specialty.

With hospice, patients receive individualized care so emphasis can be focused on improving the quality of their lives. Patients are encouraged to be independent and to participate as fully as possible in the activities of daily living. Another goal of hospice is to allow the patient to remain in the comfort of his or her own home. If a short period of hospitalization is necessary, the hospice team will also visit the hospital to maintain continuity of care.

By visiting patients regularly, the hospice nurse is able to anticipate and plan for potential problems, teach the family what to expect and make sure that the patient's pain and symptoms are well controlled. Families appreciate the 24-hour availability of the RN to answer questions, offer support, and visit in times of medical need. The hospice nurse also ensures that the patient's care can be easily managed by the family. The majority of patients are prescribed oral medications, but often in the last few days of their lives when swalllowing can become a problem, sublingual or rectal dosing is utilized. Occasionally, subcutaneous infusions are needed for severe pain, nausea or restlessness. Short periods of around-the-clock nursing are often reimbursed in situations where patients might otherwise have to be hospitalized.

The hospice team also addresses emotional and spiritual pain experienced by the patient and his/her family. For this reason, many larger hospices now employ counselors and clergy as well as social workers. Smaller hospices have volunteer clergy available to offer pastoral support if patients request this service. The hospice social worker is an important member of the hospice team who assesses and enhances the family's coping skills through individual and family counseling. The social worker will also make referrals to other community resources and assist with financial and legal tasks.

Medicare requires that hospice volunteers provide at least 5% of the patient care hours. Home care volunteers are specially trained and can provide respite care, transportation, run errands, and help in many different ways. They are assigned to assist families who desire additional support, and are often described as the "heart of hospice."

The growth and development of the hospice movement has been helped by the decision to establish the Medicare Hospice Benefit Program in 1983. Since the median age for most hospice patients is nearly 65 years old, Medicare reimbursement provides a large portion of the funding for hospices (2). In West Virginia, Medicaid and most private insurance companies also provide reimbursement for hospice care. Most hospices are not-for-profit organizations and rely on charitable contributions, fund-raising events and memorial donations, because insurance payments rarely cover the full cost of care. Many hospices provide charity care to patients who do not have insurance.

Admission criteria

Admission criteria for patients may vary from one hospice to another, but the main criterion for entry into a hospice program is a prognosis of six months or less (1). Hospice's role is to support and teach those taking care of the patient, not to provide the custodial care, so there must be a plan for how the day-to-day care will be provided.

The patient and family must understand that hospice care is palliative, so patients receiving aggressive treatment such as chemotherapy, dialysis, or hyperalimentation are not generally candidates for hospice. However, most hospices will evaluate treatment on an individual basis, and discussion with the medical director of the hospice may help when the appropriateness of a hospice referral is uncertain. The following definition of palliative care, which was approved by the National Hospice Organization in 1988, is the standard which guides decisions about the meaning of palliative care:

> "The National Hospice Organization defines palliative care for terminally ill patients (those in advanced, progressive stages of illnesses such as cancer, AIDS, and other diseases) as treatment that enhances comfort and improves the quality of the patient's life. No specific therapy is excluded from consideration. The test of palliative treatment resides in the agreement by the attending physician, the patient, the primary care support, and the hospice team that the goals of intervention are pain control, symptom management, quality of life enhancement, and spiritual-emotional comfort for patients and their primary care support. The decision to intervene or not to intervene with a palliative treatment is based on its ability to meet the goals mentioned above rather than its effect on the underlying disease. Each patient's needs must continue to be assessed and all treatment options explored and evaluated in the context of the patient's values and symptoms."

Hospices will care for patients with any diagnosis, although the model of care was originally designed for cancer patients. Cancer patients currently account for 80%-90% of hospice patients, and other diagnoses include AIDS, A.L.S., as well as endstage heart, lung and renal disease. Some hospices have developed guidelines for the admission of patients with a non-malignant diagnosis because of the difficulty of estimating when the illness is terminal. An example of the guidelines for chronic lung disease as developed by San Diego Hospice is shown below in Table 1.

Table 1. Admission Guidelines for Chronic Lung Disease Patients By San Diego Hospice

Chronic Lung Disease

Major:
1. Frequent life threatening exacerbations
2. Frequent infections

Plus two (2) minors

Minor:
1. Hypoxia constant
2. CO_2 retention
3. Persistent wheezing or bronchospasm
4. Tachyphylaxis or refractory to meds

Table 2. The Responsibilties of an Attending Physician Who Refers a Patient to Hospice Care.

(1) Approve hospice admission;

(2) Agree to remain as primary physician;

(3) Give the following to hospice - - diagnosis, prognosis, and permission to visit;

(4) Fill out physician orders, medical history, certification of terminal illness;

(5) Be available for consultation with hospice RN when medical problems arise;

(6) Continue to prescribe all necessary medications for pain and symptom management;

(7) Receive and review regular progress reports;

(8) Inform hospice of any significant changes in patient/family status and;

(9) Receive reimbursement for all services (regardless of patient's utilization of hospice benefits) from patient's insurance or Medicare Part B.

The physician's role

The attending physician has many responsibilities when he/she refers a patient for hospice care (Table 2).

One of these requirements is that the attending physician certify that the patient's illness is terminal. This physician must also agree to continue to be responsible for providing the patient's primary medical care, supported directly through the hospice interdisciplinary team (3). If a patient's physician is unavailable to provide care, then responsibility for treatment and consultation is provided by the medical director of the hospice.

For many years, medical directors of hospice programs in West Virginia were physicians who volunteered long hours caring for hospice patients. Now, several of the larger West Virginia hospices have a paid medical director. Although hospice is not yet recognized officially as a medical specialty in the United States, hospice medicine is a specialty in Great Britain, and specialty status is pending in Canada. Physician involvement in hospice medicine has led to an increase in research and knowledge about pain and symptom management, which has greatly improved the quality of care offered to patients.

Hospice care has traditionally been "high touch, low-tech;" however, technology is used when appropriate and some patients require PCA pumps or epidural analgesia to keep them comfortable. It has been generally accepted that up to 90% of pain can be relieved. Ira Byock, M.D., who is co-chair of the Ethics Committee of the Academy of Hospice Physicians, recently asserted in the Washington Post that hospices can control 100% of a patient's pain. In a small percentage of cases, sedation may have to be accepted when pain cannot be controlled. The literature supports the use of subcantaneous infusions of midazolam in rare situations when pain cannot be controlled with opiates. Byock also stated in a recent interview that "Hospice in general represents to the physician fewer calls, less panic, more feelings that things have gone well, that patients were well served by the system (4)."

The Hospice Association of America has been advocating for many years that physicians should be reimbursed for hospice care plan oversight. As of January 1, 1995, physicians were given the right to bill for hospice care plan oversight under HCPCS code 99375 when 30 or more minutes of the physician's time is involved per month. It is hoped that this new ruling will encourage physicians to refer patients earlier to hospice.

Conclusion

In an article about developing hospices by Raich and colleagues in the June 1983 issue of the *West Virginia Medical Journal,* physicians were encouraged to get involved with the hospice movement (5). This same advice holds true today. Physician involvement is essential to ensure that hospices in West Virginia offer a high standard of care.

Hospices need physicians to support them by referring appropriate patients for care and by providing feedback about how services can be improved and alerting them to problems as they arise. West Virginia hospices can support physicians in the care of their terminally-ill patients. Working together we can relieve the physical, emotional, and spiritual suffering experienced by families when a loved one is dying.

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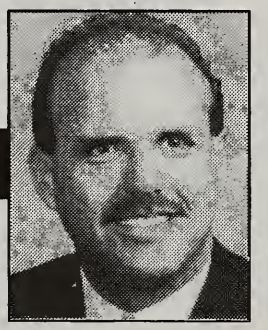
Additional resources

1. The National Hospice Organization, 1-800-658-8898, 1901 North Moore St., Suite 901, Arlington, VA 22209.
2. The Hospice Council of West Virginia, Inc., (304) 329-1161, P.O.Box 229, Kingwood, WV 26537-0229.
3. The Academy of Hospice Physicians, (904) 377-8900, P.O.Box 14288, Gainesville, FL 32604-2288.

Roger K. Pons, M.D.



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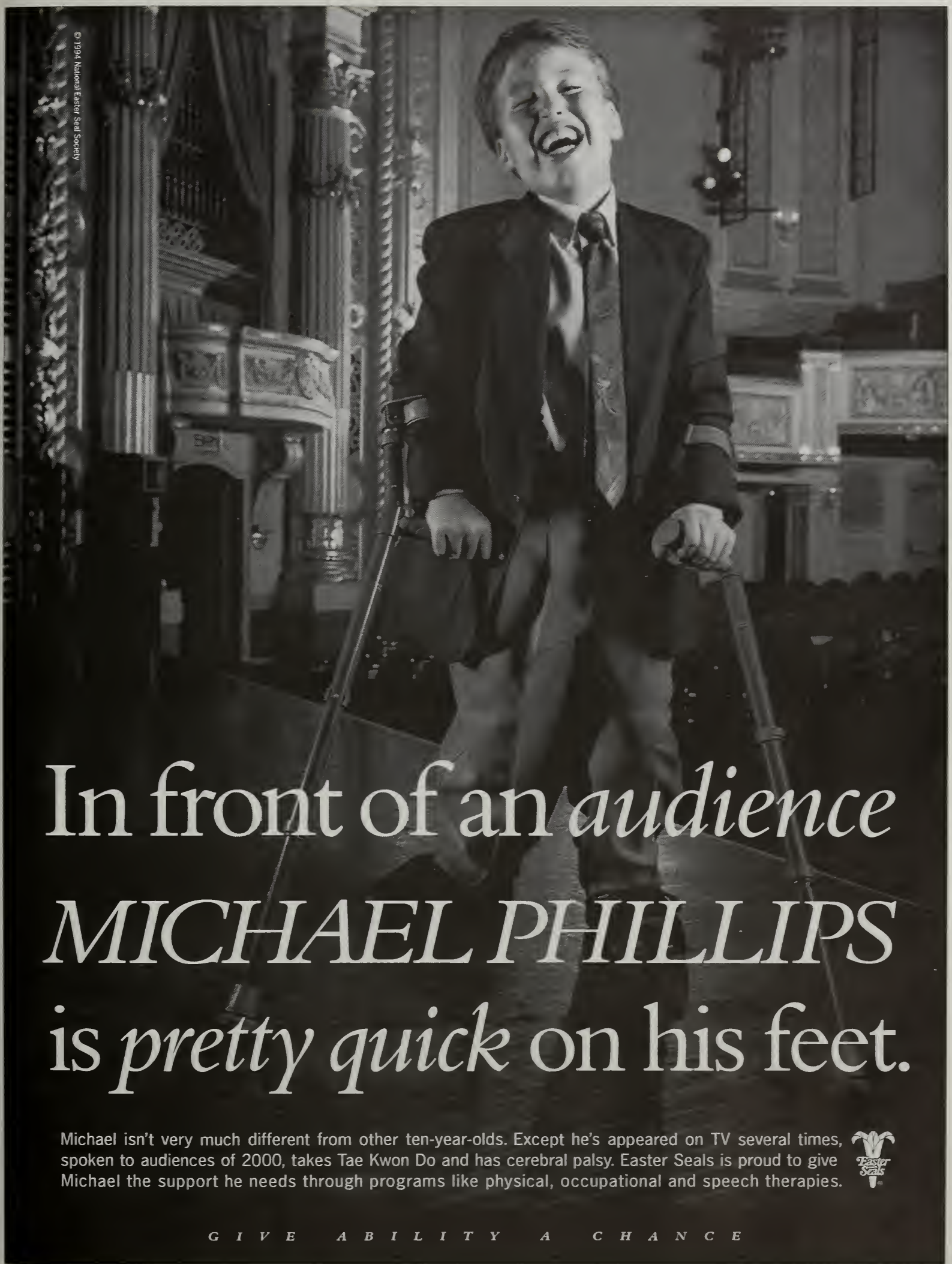
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My world now

Life in a nursing home from the inside

ANNA MAE HALGRIM SEAVER

Editor's Note: *Anna Mae Halgrim Seaver lived in Wauwatosa, Wisc., before she died in March 1994 in a nursing home. Her son, Richard H. Seaver of Brookfield, Wisc., found these notes in her room after her death. This article was published in* Newsweek *last year and WVSMA President Dr. Dennis Burton requested that it be reprinted in the* West Virginia Medical Journal. *We are reprinting it in this issue in honor of Mother's Day and Father's Day with Mr. Seaver's permission.*

This is my world now. It's all I have left. You see, I'm old. And, I'm not as healthy as I used to be. I'm not necessarily happy with it but I accept it. Occasionally, a member of my family will stop in to see me. He or she will bring me some flowers or a little present, maybe a set of slippers – I've got 8 pair. We'll visit for awhile and then they will return to the outside world and I'll be alone again.

Oh, there are other people here in the nursing home. Residents, we're called. The majority are about my age. I'm 84. Many are in wheelchairs. The lucky ones are passing through – a broken hip, a diseased heart, something has brought them here for rehabilitation. When they're well they'll be going home.

Most of us are aware of our plight – some are not. Varying stages of Alzheimer's have robbed several of their mental capacities. We listen to endlessly repeated stories and questions. We meet them anew daily, hourly or more often. We smile and nod gracefully each time we hear a retelling. They seldom listen to my stories, so I've stopped trying.

The help here is basically pretty good, although there's a large turnover. Just when I get comfortable with someone he or she moves on to another job. I understand that. This is not the best job to have.

I don't much like some of the physical things that happen to us. I don't care much for a diaper. I seem to have lost the control acquired so diligently as a child. The difference is that I'm aware and embarrassed but I can't do anything about it. I've had 3 children and I know it isn't pleasant to clean another's diaper. My husband used to wear a gas mask when he changed the kids. I wish I had one now.

Why do you think the staff insists on talking baby talk when speaking to me? I understand English. I have a degree in music and am a certified teacher. Now I hear a lot of words that end in "y." Is this how my kids felt? My hearing aid works fine. There is little need for anyone to position their face directly in front of mine and raise their voice with those "y" words. Sometimes it takes longer for a meaning to sink in; sometimes my mind wanders when I am bored. But there's no need to shout.

I tried once or twice to make my feelings known. I even shouted once. That gained me a reputation of being "crotchety." Imagine me, crotchety. My children never heard me raise my voice. I surprised myself. After I've asked for help more than a dozen times and received nothing more than a dozen condescending smiles and a "Yes, deary, I'm working on it," something begins to break. That time I wanted to be taken to a bathroom.

I'd love to go out for a meal, to travel again. I'd love to go to my own church, sing with my own choir. I'd love to visit my friends. Most of them are gone now or else they are in different "homes" of their children's choosing. I'd love to play a good game of bridge but no one here seems to concentrate very well.

"Am I invisible? Have I lost my right to respect and dignity?"

My children put me here for my own good. They said they would be able to visit me frequently. But they have their own lives to lead. That sounds normal. I don't want to be a burden. They know that. But I would like to see them more. One of them is here in town. He visits as much as he can.

Something else I've learned to accept is loss of privacy. Quite often I'll close my door when my roommate – imagine having a roommate at my age – is in the TV room. I do appreciate some time to myself and believe that I have earned at least that courtesy. As I sit thinking or writing, one of the aides invariably opens the door unannounced and walks in as if I'm not there. Sometimes she even opens my drawers and begins rummaging around. Am I invisible? Have I lost my right to respect and dignity?

What would happen if the roles were reversed? I am still a human being. I would like to be treated as one.

The meals are not what I would choose for myself. We get variety but we don't get a choice. I am one of the fortunate ones who can still handle utensils. I remember eating off such cheap utensils in the Great Depression. I worked hard so I would not have to ever use them again. But here I am.

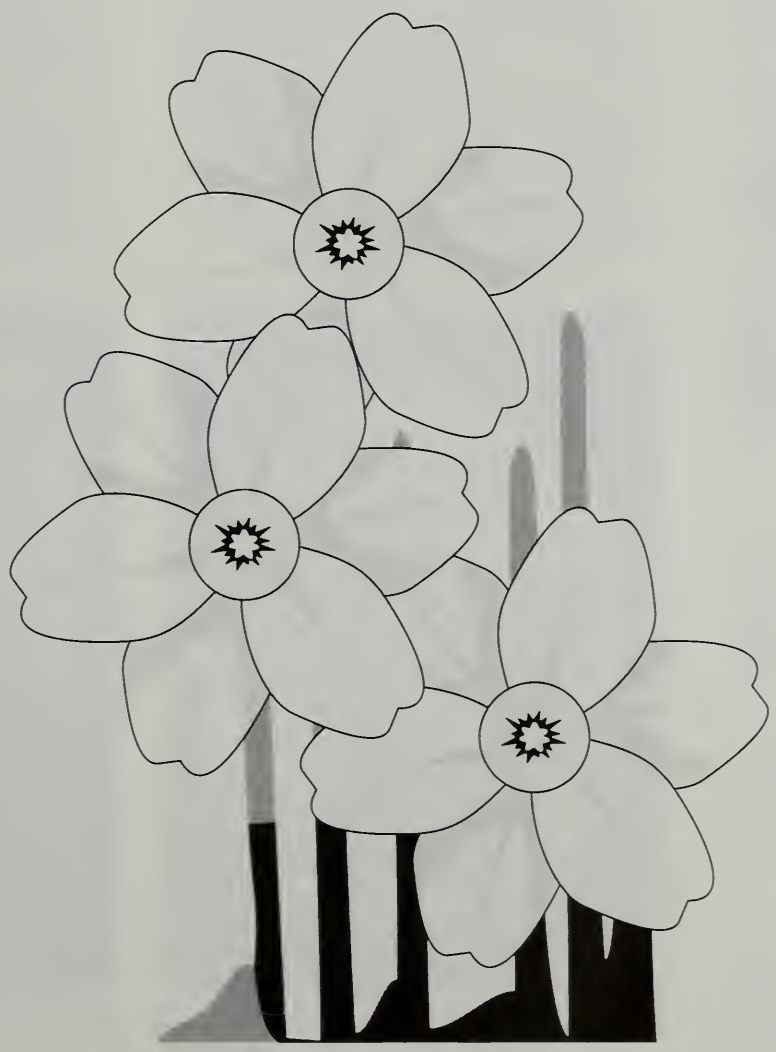
Did you ever sit in a wheelchair over an extended period of time? It's not comfortable. The seat squeezes you into the middle and applies constant pressure on your hips. The armrests are too narrow and my arms slip off. I am luckier than some. Others are strapped into their chairs and abandoned in front of the TV. Captive prisoners of daytime television; soap operas, talk shows and commercials.

One of the residents died today. He was a loner who, at one time, started a business and developed a multimillion-dollar company. His children moved him here when he could no longer control his bowels. He didn't talk to most of us. He often snapped at the aides as though they were his employees. But he just gave up; willed his own demise. The staff has made up his room and another man has moved in.

A typical day. Awakened by the woman in the next bed wheezing – a former chain smoker with asthma. Call an aide to wash me and place me in my wheelchair to wait for breakfast. Only 67 minutes until breakfast. I'll wait. Breakfast in the dining area. Most of the residents are in wheelchairs. Others use canes or walkers. Some sit and wonder what they are waiting for. First meal of the day. Only 3 hours and 26 minutes until lunch. Maybe I'll sit around and wait for it. What is today? One day blends into the next until day and date mean nothing.

Let's watch a little TV. Oprah and Phil and Geraldo and who cares if some transvestite is having trouble picking a color-coordinated wardrobe from his husband's girlfriend's mother's collection. Lunch. Can't wait. Dried something with puréed peas and coconut pudding. No wonder I'm losing weight.

Back to my semiprivate room for a little semiprivacy or a nap. I do need my beauty rest, company may come today. What is today again? The afternoon drags into early evening. This used to be my favorite time of the day. Things would wind down. I would kick off my shoes. Put my feet up on the coffee table. Pop open a bottle of Chablis and enjoy the fruits of my day's labor with my husband. He's gone. So is my health. *This* is my world.



Esthesioneuroblastoma: An unusual cause of frontal lobe dysfunction

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Abstract

Esthesioneuroblastoma (olfactory neuroblastoma) is an unusual tumor of neuroectodermal origin, and initial presentation with symptoms characteristic of frontal lobe dysfunction is quite rare. This article describes the case of a patient who was referred to the Charleston Area Medical Center for "depression" but was found to have a esthesioneuroblastoma.

Introduction

Esthesioneuroblastoma (olfactory neuroblastoma) is an unusual tumor of neuroectodermal origin (1), which was first reported in 1924 (2). Since this first case was discovered, over 300 cases have been described in the literature, and these tumors are also referred to as esthesioneuroepitheliomas, esthesioneurocytomas, and olfactory neurocytomas (3). They represent approximately 3% of intranasal tumors, excluding polyps (4).

The most common presenting symptoms of esthesioneuroblastomas are epistaxis and nasal obstruction (5). Other common presenting symptoms are rhinorrhea, anosmia, retro-orbital or nasal pain and headache (6). This tumor has rarely presented with psychiatric or behavioral manifestations, and this article reports the case of a patient who was referred to Charleston Area Medical Center for depression, but was actually suffering from an esthesioneuroblastoma.

Case report

A 55-year-old white male executive with no previous psychiatric problems was referred for psychiatric evaluation at the urging of co-workers and family because his behavior had changed so dramatically over the preceding two months. He had already undergone several weeks of antidepressant treatment at another facility but had shown no improvement.

This patient reported decreased interest, anhedonia, decreased libido and hypersomnolence. He frequently was tardy or would not go to work as a result of apathy and indifference. He also had become very neglectful of his grooming and hygiene, and described a remote history of "sinus problems" and a recent onset of frontal headaches.

On examination, this patient was unshaven and poorly groomed. He had a blank facial expression and his speech was monotonal. He appeared listless and apathetic, and stated that his family was overreacting. Repeatedly, he denied feeling depressed, sad or hopeless. His physical examination and neurological examination was non-focal (although olfactory nerve function was not assessed).

His cranial CT showed a large, soft tissue mass involving the nasal cavity with extension into the orbits and both frontal lobes. (Figure 1). He underwent surgical resection followed by radiation therapy and combination chemotherapy. Histologic examination confirmed the tumor to be an esthesioneuroblastoma (Figure 2).

Discussion

Esthesioneuroblastoma is an unusual tumor which is thought to arise from the neurosensory receptor cells of the olfactory mucosa, most commonly in the lateral and superior aspects of the nasal cavity (7). Males and females are approximately equally affected and there is a bimodal age distribution among patients with this condition, with peaks occurring in the second and sixth decades of life (8).

Epistaxis, nasal obstruction, anosmia, rhinorrhoea, tearing, pain, and proptosis are the most frequent presenting symptoms (5,6).

Figure 1. Cranial CT images showing soft tissue mass involving nose, orbits, with extension into both frontal lobes of the brain.

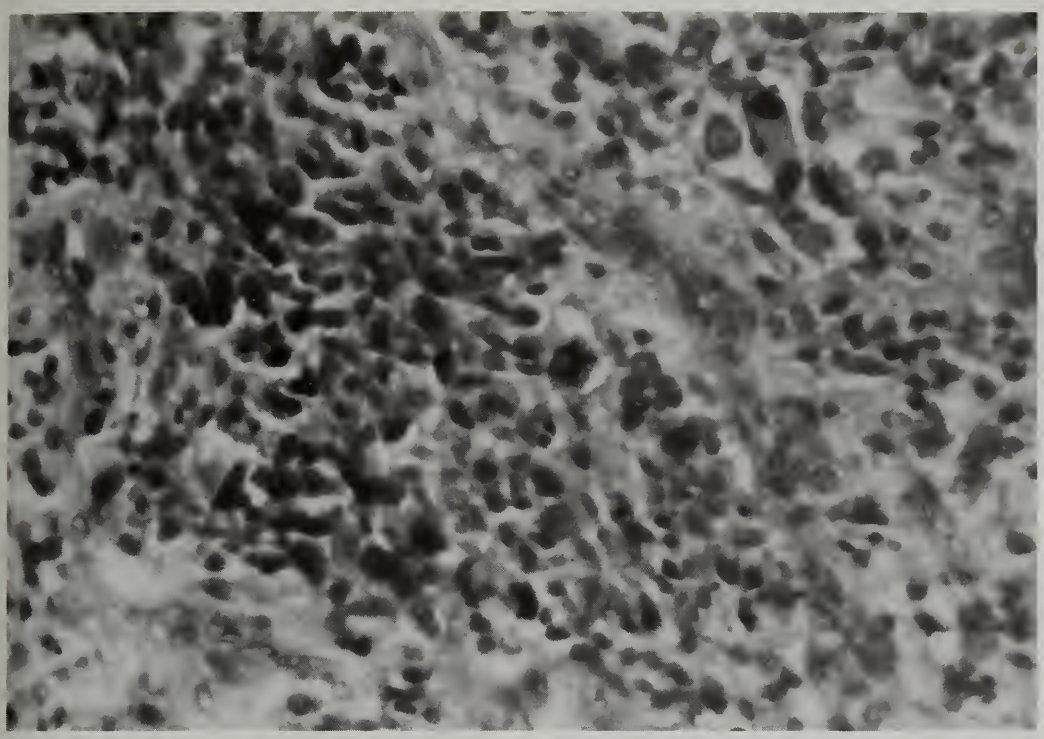

Figure 2. Histologic section showing sheets of closely, packed, immature cells with prominent nucleoli and frequent mitoses. The specimen also stained positive for synaptophysin, confirming presence of neurotransmitter, characteristic of esthesioneuroblastoma.

Esthesioneuroblastomas are generally staged according to the system developed by Kadish (Table 1). Intracranial extension occurs often (20%), and presentation as an intracranial mass has been rarely reported and previously reviewed (10,11). Despite frequent intracranial tumor spread, patients with primarily behavioral or psychiatric symptoms have been quite rare. Only two previous cases of esthesioneuroblastoma presenting with behavioral symptoms have been reported (12,13).

This patient presented with behavioral and mental status features of frontal lobe dysfunction. Although no single consistent behavioral pattern can be called characteristic of "frontal lobe syndrome" (14), some symptoms have been frequently observed in patients with structural damage to the frontal lobes. Extreme apathy (abulia), indifference, loss of motivation, disinterest, and psychomotor retardation are often associated with frontal lobe damage (14). However, most patients do not report experiencing depression.

Thus, it is critical to distinguish depression from frontal lobe dysfunction, since the latter requires brain imaging for prompt detection of the etiology. The problem of misdiagnosis of patients with slow-growing frontal lobe tumors as having psychiatric illness leading to delays in treatment has been previously noted (14).

Table 1. Staging of Esthesioneuroblastoma According to Kadish and Colleagues

A. Disease confined to the nasal cavity

B. Disease confined to the nasal cavity and one or more paranasal sinuses.

C. Disease extending beyond the nasal cavity or paranasal sinuses. Includes involvement of orbit, base of skull or intracranial cavity, cervical lymph nodes, or distant metastatic sites.

Conclusions

Esthesioneuroblastoma is a rare cause of frontal lobe dysfunction. The low number of reported cases of esthesioneuroblastoma presenting with behavioral symptoms may be related to the fact that other more common symptoms may predominate and direct attention to the tumor. In addition, signs of frontal lobe dysfunction can often be quite subtle and may escape detection.

Psychiatric and/or neuropsychologic evaluation of esthesioneuroblastoma patients with intracranial extension may lead to a higher detection rate of frontal lobe dysfunction. Distinguishing frontal lobe dysfunction from depression remains an important clinical challenge. Failure to recognize signs of frontal lobe damage can lead to delays in diagnosis and treatment.

Acknowledgements

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The West Virginia Cancer Registry: Historical development and preliminary results

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Abstract

This article is designed to provide the medical community with an overview of the West Virginia Cancer Registry (WVCR), a population-based registry, which was established in 1993 with both federal and state funding. The WVCR is managed through the Bureau for Public Health's Division of Surveillance and Disease Control in the Office of Epidemiology and Health Promotion, and all data is confidential. The staff of the WVCR consists of a director, a cancer data supervisor, two abstractors, a secretary, and a voluntary, 13-member Cancer Advisory Committee. The initial findings of the WVCR have shown that for each 100,000 West Virginia women, 90.1 were discovered with invasive breast cancer in 1992, an increase from 86.8 in 1991. The invasive cervical cancer rate increased from 10.8 to 12.9 during this same time period. In addition, the age-adjusted death rate for cervical cancer rose from 3.6 cases per 100,000 women in 1991 to 3.8 in 1992. However, the age-adjusted death rate for breast cancer fell to 24.7 per 100,000 women in 1992, compared to 25.5 in 1991.

Historical background

From 1957 through 1977, the West Virginia State Health Department and the West Virginia Division of the American Cancer Society jointly sponsored a non-computerized central cancer registry. During that period, cancer was not a mandated reportable disease in West Virginia, and reporting from hospitals in the state was voluntary.

This non-computerized cancer registry was discontinued in 1977, but in 1989, the West Virginia Department of Health and Human Resources proposed a feasibility study for a statewide cancer registry because there was such a nationwide interest in central cancer registries. In addition, since there were 10 hospital-based tumor registries in place in 1989 and due to the fact that cancer had been included on the reportable disease list since 1980, a central cancer registry was the next step in collecting statewide cancer data.

In 1991, the West Virginia Bureau of Public Health received a federal grant from the U.S. Centers for Disease Control and Prevention (CDC) for a breast and cervical screening program for uninsured and underinsured women in West Virginia. As part of the surveillance component of this program, a Breast and Cervical Cancer Incidence Registry (BCCIR) was established. This population-based registry has produced two annual reports (1991 and 1991-92) concerning breast and cervical cancer morbidity and mortality rates.

Due to the growing awareness of the potential for a statewide West Virginia cancer registry, the Legislature adopted an amendment in 1992 to the West Virginia Code (Chapter 16-5A-2a) to establish a central cancer registry to collect data about cancer found in any anatomical site among all residents of West Virginia. With additional state funding, the BCCIR was expanded to the WVCR in 1993, to be fully phased in over a three-year period and publish annual reports of all data.

Facilities and personnel

The WVCR is managed through the Bureau for Public Health's Division of Surveillance and Disease Control, Office of Epidemiology and Health

Table 1. The 17 Hospital Tumor Registries in West Virginia

Camden-Clark Memorial Hospital	Parkersburg
Cancer Care Center of Southern WV, Memorial Division of CAMC	Charleston
City Hospital, Inc.	Martinsburg
Jackson General Hospital	Ripley
Jefferson Memorial Hospital	Ranson
Monongalia General Hospital	Morgantown
Ohio Valley Medical Center	Wheeling
Preston Memorial Hospital	Kingwood
Princeton Community Hospital Library	Princeton
Reynolds Memorial Hospital	Glen Dale
St. Francis Hospital	Charleston
St. Mary's Hospital	Huntington
United Hospital Center, Inc.	Clarksburg
Veterans Administration Medical Center	Beckley
Veterans Administration Hospital	Clarksburg
West Virginia University Hospital	Morgantown
Wheeling Hospital	Wheeling

Promotion. The staff consists of a director, a cancer data supervisor, two abstractors, and a secretary.

The cancer registry legislation also provides that a Cancer Registry Advisory Committee be appointed to "provide technical guidance regarding the operation of the cancer registry and to provide advice and assistance as needed to carry out effective cancer prevention and control activities." This 13-member committee has met quarterly since it was established in August 1992 and has been active in guiding the WVCR in its formative period.

Case findings and reporting

There are currently 17 hospital-based tumor registries in West Virginia that report cases to the WVCR monthly via computer diskette or batches of paper abstracts (Table 1) . All other hospitals and pathology laboratories in the state are visited on a regular basis by the WVCR staff who conduct casefinding and abstracting activities.

Other reporting sources for the WVCR include cytology laboratories, physicians' offices, clinics, cancer treatment centers, nursing homes, the Breast and Cervical Screening Program, death certificates, and other state cancer registries.

Confidentiality

Chapter Sixteen of the West Virginia Code and the Cancer Registry Legislative Rules stipulates that information identifying individual cancer patients, individual hospitals, or individual physicians is regarded as confidential and must be carefully guarded. To insure this confidentiality, all WVCR staff members must sign a confidentiality agreement as soon as they are hired.

Information which identifies a specific patient is only released to the reporting source or to a central tumor registry in another state with which a reciprocal agreement has been made for the exchange of data. The WVCR has such agreements with four states and these agreements specifically address confidentiality requirements.

Findings on breast cancer

In 1992, 1,155 West Virginia women were diagnosed with invasive breast cancer, and an additional 136 women were diagnosed with carcinoma in situ. The age-adjusted incidence rate of invasive female breast cancer increased from 86.8 per 100,000 in 1991, to 90.1 per 100,000 in 1992. In addition, the age-adjusted mortality rate decreased slightly from 25.5 per 100,000 in 1991 to 24.7 per 100,000 in 1992 (Table 2)(1).

TABLE 2. WVCR Findings Regarding West Virginia Women and Breast Cancer, 1991-92

YEAR	NEW CASES*	CRUDE INCIDENCE RATES**	AGE-ADJUSTED INCIDENCE RATES**
1991	1,103	1,17.8	86.8
1992	1,115	122.8	90.1

YEAR	DEATHS	CRUDE INCIDENCE RATES**	AGE-ADJUSTED INCIDENCE RATES**
1991	336	36.1	25.5
1992	327	35.1	24.7

* Excludes In Situ cases

** Rates are per 100,000 WV women and are age-adjusted to the 1970 U.S. standard population.

TABLE 3. WVCR Findings Regarding West Virginia Women and Cervical Cancer, 1991-92

YEAR	NEW CASES*	CRUDE INCIDENCE RATES**	AGE-ADJUSTED INCIDENCE RATES**
1991	125	13.3	10.8
1992	145	15.4	12.9

YEAR	DEATHS	CRUDE INCIDENCE RATES**	AGE-ADJUSTED INCIDENCE RATES**
1991	42	4.5	3.6
1992	46	4.9	3.8

* Excludes In Situ cases

** Rates are per 100,000 WV women and are age-adjusted to the 1970 U.S. standard population.

Current state-specific data reported by the Surveillance Epidemiology and End Results (SEER) Program using public use tapes from the National Center for Health Statistics (NCHS) indicates that age-adjusted mortality for female breast cancer in West Virginia during 1986-1990 was 36th highest among the 50 states and the District of Columbia (2). Other published data indicates that breast cancer mortality rates in West Virginia are similiar to rates of U.S. women as a whole (3,4,5).

Findings on cervical cancer

In 1992, 145 West Virginia women were diagnosed with invasive cervical cancer. The age-adjusted incidence rate of invasive cervical cancer increased slightly from 10.8 per 100,000 in 1991, to 12.9 per 100,000 in 1992. In addition, the age-adjusted mortality rate increased from 3.6 per 100,000 in 1991 to 3.8 per 100,000 in 1992 (Table 3)(1).

Recently published data reported by the SEER Program utilizing public use tapes from NCHS indicates that West Virginia ranked fifth highest among the 50 states and the District of Columbia in age-adjusted mortality from cervical cancer during 1986-1990 (2). Several studies have also demonstrated that cervical cancer mortality is greater in West Virginia than in the U.S. as a whole (3,4,5).

Future of the WVCR

Data from a population-based cancer registry such as the WVCR can be used to monitor trends in cancer incidence, determine the need for further epidemiologic investigation and public health action, as well as assist in the evaluation of cancer control programs. Since mortality due to breast and cervical cancer has not changed substantially over two years, current data from the WVCR underscores the need to ensure that every woman in the state (for whom it is deemed appropriate) receive regular screening for the early detection of breast and cervical cancer, prompt follow-up if necessary, and assurance that tests are performed in accordance with current recommendations for quality standards.

In the short time the WVCR has been in existence, much has been accomplished to implement a computerized population-based cancer registry. The creation and maintenance of the WVCR has occurred through the superior cooperation of staff from reporting sources in the state and neighboring areas.

Future goals of the WVCR are to:

1) Aid in the establishment of tumor registries in more West Virginia hospitals, since there are currently only 17 hospital-based registries out of 60 acute care hospitals;

2) Pursue data exchange agreements with a greater number of state registries;

3) Actively comply with national standards of timeliness, completeness, and quality for reporting of cancer data; and

4) Analyze and report data for all anatomical sites among West Virginians.

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All scientific manuscripts should be submitted on an IBM compatible disc in Wordperfect 5.1 or in ASCII (generic). They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

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Exacerbation of soft tissue rheumatism by excess Vitamin A: Case reviews with clinical vignette

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Abstract

In certain situations, health problems can arise if physicians are not aware of over-the-counter medications and vitamins a patient may be taking in addition to their regular prescriptions. Since many people do not consider OTC drugs to be medications, they often do not relay this information while discussing their medical histories. This article describes how the symptoms of soft tissue rheumatism can become worse if patients ingest an excess amount of vitamin A.

Introduction

The importance of obtaining a thorough medical history from patients was recently reinforced by an AMA study which showed that 56% of correct diagnoses could be on the basis of history alone (1). Since many people do not consider over-the-counter (OTC) drugs or vitamins to be medications, they often do not offer information about OTC items to their physicians when relaying their medical histories.

The omission of this information can sometimes be harmful, for example in situations where patients are taking vitamins and receive an excess amount of vitamin A (2,3,4,5). This paper describes how the symptoms of soft tissue rheumatism can worsen if patients ingest an excess of vitamin A.

Methods

The blood levels of 12 patients in my practice who were not responding to conventional treatments for soft tissue rheumatism were checked to determine the amount of vitamin A present. Vitamin A levels were performed by Vitamin Diagnostics of Clifford Beach, N.J., utilizing the assay described by Baker and Frank (6).

Five of these patients were diagnosed as having fibromyalgia syndrome (FS) according to American College of Rheumatology's 1990 criteria (7); another five patients had myofascial pain syndrome (MPS), which had been diagnosed using the criteria of Travell and Simons (8); and the other two patients had both FS and MPS. Of these patients, five were men ranging in age from 39-50, and seven were women ranging in age from 19-59.

All of the patients in the study were taking some variety of OTC vitamin preparations. Three of the patients were taking multivitamins, such as the "One-a-Day" type; two patients were using "anti-oxida" mixtures found in health food stores; and two patients were taking vitamin A/beta carotene preparations. In addition, two of the patients had recently ingested a combination of these preparations, while three patients stated they did not remember increasing their vitamin supplement intake in anyway.

Results

The mean vitamin A level in the patients studied was 77.33 ug% (standard deviation, 25.5 ug%). Compared to the laboratory reference group's mean of 50 ug% (standard deviation 12.5 ug%), this was a very statistically significant difference ($p < 0.001$).

The vitamin A levels in the 12 patients ranged from 39 - 135 ug%, and five patients had values higher than the upper limit of the laboratory reference range of 25-75 ug%. In all cases, symptoms improved to varying degrees after the exogenous vitamin A intake ceased.

Clinical vignette

The dramatic effect that vitamin A had on these 12 patients is best illustrated by one of the patients who was a 56-year-old female. This woman developed FS and a multi-regional MPS after a motor vehicle accident.

I treated this woman successfully with bedtime tricyclic medication and non-acetylated salicylate medication three times daily, as well as occasional tender/trigger point injections. However, she suddenly became unresponsive to this treatment.

After further questioning, I determined that the only change in her routine was the addition of daily vitamin A pills starting about six months prior to the exacerbation of her musculoskeletal symptoms. Her vitamin A level was 108 ug%. Two months after stopping the vitamin, her soft tissue rheumatism symptoms became more controllable.

Discussion

Vitamin imbalances have been shown to be perpetuating factors in MPS (9). Both hypovitaminosis and hypervitaminosis can aggravate the symptoms of MPS and impede therapy.

The case of the woman described in the clinical vignette shows how serendipitous vitamin A intake with resultant hypervitaminosis can aggravate MPS. In contrast with the cases of soft tissue rheumatism with high vitamin A levels which were also described in this article, patients with rheumatoid arthritis tend to have low levels of vitamin A (10).

Patients with MPS who take vitamin A or vitamin preparations high in vitamin A, may unwittingly be worsening their soft tissue rheumatism and interfering with treatment. By recognizing vitamin A excess in such patients and possibly by analyzing other vitamin levels, physicians can more rationally advise patients as to vitamin intake. While I do not recommend obtaining vitamin levels in all patients with soft tissue rheumatism, these levels may be useful in patients with unusual symptoms or those who become unresponsive to treatment.

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Medical Grand Rounds

Robert C. Byrd Health Sciences Center of WVU
Edited by Irma H. Ullrich, M.D., Professor of Medicine, Section of Endocrinology and Metabolism

Gestational diabetes

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Abstract

The complication of diabetes during pregnancy can be a disaster for both mother and child. However, proper management of diabetes prior to conception and during pregnancy has enabled diabetics to have normal infants nearly as often as non-diabetic women. This article reviews the historical aspects of gestational diabetes, the magnitude of the problem, carbohydrate metabolism during pregnancy, appropriate therapy, and offers some suggestions about how gestational diabetes and non-insulin dependent diabetes might be prevented.

Historical aspects

Before insulin was available, the occurrence of pregnancy in a known diabetic was unusual. Women with severe Type I diabetes (insulin-dependent) were usually catabolic and did not have normal ovulatory menstrual cycles, therefore they were unlikely to become pregnant. The women who had less severe diabetes and became pregnant died at a rate of 30%, and their infants had a mortality rate of 65% (1).

Since insulin has been used for treatment, most women with diabetes are able to become pregnant and have a normal baby. In addition, by the late 1970s and early 80s, there had been a marked decrease in perinatal mortality which was related to an improvement in the mean maternal glucose level. The perinatal mortality in most centers is now 3%-5%, which is still higher than the 1%-2% noted in non-diabetic pregnancies. Congenital abnormalities, which may play a role in this increased perinatal mortality, continue to be greater in frequency than the 2.4% reported in non-diabetic mothers. One study (2) in the early 1980s cited a 10.9% incidence of congenital anomalies in infants of known diabetics and a 4.9% incidence in those mothers with diabetes which had begun or was recognized during the pregnancy (gestational diabetes).

The pioneering research related to discovering possible mechanisms responsible for these congenital abnormalities is interesting and enlightening. Research was stimulated by the early observation that glycosylated hemoglobin levels were elevated during the first trimester of these pregnancies. Since glycosylated hemoglobin is a measure of glucose level during the preceding 4-6 weeks, this indicated that glucose levels were likely to be elevated at conception and very early in the pregnancy.

Although hyperglycemia was implicated, other changes in maternal metabolism, placental function or circulatory problems may have been responsible for these abnormalities. An in vitro system would allow testing of individual substances without influence of other factors.

Norbert Freinkel (3) is credited with much of the early work which used whole rat embryo cultures using strains which did not normally develop diabetes. Incubation of the embryos in a culture medium containing increased glucose concentrations resulted in abnormalities of the heart and nervous system. Abnormalities were related to the glucose concentration and occurred only if glucose was high during a specific time during embryogenesis. Incubation with various ketone bodies also promoted abnormal growth with a possible synergistic effect among these compounds and glucose.

Freinkel's research and other studies suggested that in order to prevent congenital abnormalities, maternal metabolism should be normalized at conception and very early in the pregnancy. Pre-pregnancy counseling has been shown in some centers to decrease the rate of major congenital abnormalities. Since most of the increase in perinatal mortality is due to major congenital malformation, a decrease in perinatal mortality would be expected as well.

There is controversy, though, as to whether gestational diabetic women do indeed have infants with more abnormalities than non-diabetics. This may relate to how gestational diabetes is diagnosed. By definition, gestational diabetes is diabetes which has its onset or is discovered during pregnancy. Therefore, a woman may have undiagnosed, asymptomatic hyperglycemia in early pregnancy if she hasn't had early prenatal care or if testing wasn't done. Controversy also exists also among obstetricians about the need for universal screening.

Primary care providers may also play a role in the early diagnosis of diabetes in women since they would be aware of patients with a strong family history of diabetes or other known risk factors for development of diabetes, that are likely to become pregnant. This is also true during the time between pregnancies when diabetes may have disappeared, but is likely to return.

Magnitude of the problem

Three to five percent of all pregnancies are complicated by gestational diabetes due to a variety of factors. In a study of 10,187 women who were screened at Mt. Sinai Hospital in New York City, 3.2% had gestational diabetes (4). Women, ages 35-39, had nearly four times the relative risk of developing diabetes compared to younger women. Of those over age 40, 8.4% had gestational diabetes.

Other factors which contributed to a higher rate of diabetes in the women studied included race and previous preterm or stillborn pregnancies. Non-caucasian women, especially women born in Puerto Rico, were more likely to have gestational diabetes, as were women whose had previous pregnancies in which the infant was delivered early or stillborn.

Obese women, especially those who were severely overweight (body mass index over 32.9), were diabetic 10.6% of the time. Family history of diabetes was a positive risk factor for indigent patients only, not those women seen on the private obstetrical service. Lower socioeconomic status, as reflected by a lack of health insurance, as well as a history of infertility, were also risk factors.

The Mt. Sinai study suggests gestational diabetes may be more of a prevalent problem for women who postpone starting their families. If risk factors of obesity, poverty, and family history of diabetes are as important in West Virginia as noted in New York City, it is likely that women in West Virginia have more gestational diabetes than may be suspected.

A recent survey of 50 consecutive deliveries at Ruby Memorial Hospital in Morgantown revealed one case of gestational diabetes and another case with a single abnormality on glucose tolerance test. Extending these observations would indicate that we have a rate of 2%-4% of gestational diabetes. Additionally, in this survey there were four infants who weighed over 4,000 gms. Their mothers were severely overweight and may have had subtle abnormalities in carbohydrate metabolism which were undetected by a simple glucose tolerance test.

Carbohydrate metabolism

Pregnancy results in changes in carbohydrate metabolism because of anabolic and nutritional requirements of the growing fetus, as well as hormones produced by the placenta. Pregnancy has been described as a state of "accelerated starvation" for the mother (5).

Glucose is an energy source for protein synthesis for the fetus as well as a source for fetal triglycerides and glycogen. Glucose utilization by the fetus is estimated at 6 mg/kg/min, about three times the rate in adults (6); and glucose levels in the fetus are 10-20 mg/dl lower than maternal levels. Since glucose reaches the fetus through the placenta by facilitated diffusion, if glucose is high in the maternal circulation, more will be delivered to the fetus.

On the other hand, maternal insulin and glucagon are not transferred to the fetus. Fetal insulin secretion begins at 9-11 weeks gestational age and is stimulated by glucose and amino acids. Hyperinsulinemia in the fetus may be important in producing macrosomia since insulin levels have been found to be elevated in infants with macrosomia.

In an animal model, infusion of insulin to a Rhesus monkey fetus while maintaining normoglycemia also resulted in macrosomia (7). These observations suggest that some late complications may be due to the potent growth stimulating properties of insulin.

Amino acids are actively transported from mother to fetus. This may result in lower maternal levels of amino acids such as alanine, which are important in gluconeogenesis and may be responsible for fasting maternal hypoglycemia. Maternal ketone bodies and perhaps free fatty acids are also transported to the fetus.

During early pregnancy, non-diabetic women have maternal glucose levels that are 15-20 mg/dl lower after a 12-hour fast compared to their glucose levels when they were not pregnant. Hypoglycemia worsens if fasting is continued for longer periods. Insulin levels are appropriately low and ketones increase as fats are used for fuel.

As already mentioned, the hypoglycemia may be due to lower levels of alanine which causes less glucose formation. Hypoglycemia may also be due to increased fetal consumption of glucose. The volume of glucose distribution is also increased to include the mother, fetus and placenta.

Fasting also results in ketone production. There is controversy whether ketones alone are detrimental to infant brain development or whether other metabolic abnormalities must also be present.

On the other hand, postprandial levels of insulin are elevated during pregnancy in non-diabetic women, becoming more elevated during late pregnancy. Despite this increase in insulin secretion, the glucose level does not fall as rapidly as in the non-pregnant state, so there is a state of insulin resistance present in late pregnancy. Placental hormones, such as human placental lactogen, have been implicated in being responsible for this insulin resistance, as have hormones such as cortisol. Gestational diabetes and non-insulin dependent diabetes are similar in that both have a genetic susceptibility, peripheral insulin resistance, and an inability to secrete adequate insulin levels to compensate for the insulin resistance.

Frequent blood sampling after intravenous glucose administration and computer modeling analysis have been used to estimate early and late phase insulin secretion. The early phase represents secretion of stored insulin while the late phase reflects new synthesis.

Buchanan evaluated glucose and insulin levels in groups of normal pregnant, non-pregnant, and women with gestational diabetes (8). His research indicated that the glucose level was of course, higher in the diabetics, and that first phase insulin level was higher in the pregnant women who had normal glucose tolerance and lower in the diabetics but similar to that of the non-pregnant women. In addition, the study revealed that the glucose level in the second phase was higher in the diabetics than in the non-pregnant group, but only about half the level of the women in the pregnant, non-diabetic group.

Buchanan's study, therefore, indicates that those with diabetes had impaired insulin secretion. Insulin action, insulin sensitivity or resistance, was similar in the pregnant subjects who were of similar body weight. Obesity is a known cause of insulin resistance and may exaggerate resistance due to pregnancy. This may explain the observation that obesity is a potent risk factor for development of gestational diabetes. Insulin binding and muscle tyrosine kinase activity are not affected in women with gestational diabetes, indicating that these are not the location of the insulin resistance.

Diagnostic criteria

Since carbohydrate metabolism is altered during normal pregnancy, the criteria for definition of diabetes are different than in the non-pregnant state.

The American Diabetes Association has issued a Position Statement indicating that to make a diagnosis of gestational diabetes, two or more venous glucose samples after 100 gms oral glucose should meet or exceed the following values: fasting 105 mg/dl; 1 hour 190 mg/dl; 2 hours 165 mg/dl and 3 hours 145 mg/dl (9). It is recommended that all pregnant women be screened at 24-28 weeks of gestation with 50 gms of oral glucose.

A one-hour value of over 140 mg/dl indicates the need for a full glucose tolerance test.

Some investigators have suggested that even lower glucose levels should trigger further investigation and therapy. The criteria which are used for diagnosis will influence the rate of subsequent diabetes development. The predictive value of more severe abnormalities is higher than if only mild glucose intolerance is present. Development of abnormal glucose tolerance earlier rather than later during pregnancy is also predictive of future diabetes development.

Therapy

Therapy for gestational diabetes involves diet and medication, as well as exercise. As in other areas of diabetes care, there has been controversy regarding the amount of carbohydrates to be included in the diet. In one study, restriction of carbohydrates to 40% resulted in improved postprandial glucose level (10).

In treating patients with gestational diabetes, simple sugars should be eliminated from the diet, but increased dietary fiber may improve glucose levels. Patients are asked to increase the number of meals and snacks they eat each day to distribute the carbohydrate load over the day. Severe caloric restriction is not recommended for obese women because ketones produced during starvation may cause abnormal brain maturation (11). A weight gain of 24-27 pounds during pregnancy is therefore recommended even in obese women.

If dietary management is not successful in one to two weeks, then additional therapy is considered. Success is defined as a fasting glucose of ≤ 105 mg/dl and a two-hour postprandial glucose of ≤ 120 mg/dl.

Oral agents such as tolbutamide are used in Europe without apparent ill effects, but in the U.S., insulin is recommended. A combination of intermediate and regular human insulin in divided doses is used with the goal to reach a fasting glucose level of ≤ 105 mg/dl, and a two-hour postprandial of ≤ 120 mg/dl. Insulin requirements increase as pregnancy continues because of higher levels of placental hormones.

Regular moderate exercise may also play a therapeutic role in gestational diabetes because of its effects on decreasing insulin resistance in skeletal muscle (11). Additionally, the increased caloric expenditure brought about by exercise will help prevent excessive weight gain in pregnancy, as well as possibly prevent or lessen hypertension and hyperlipidemia (12). Some studies have also shown that duration of labor is decreased in those women who exercise - - a practical concern for the pregnant woman.

There are risks to exercise during pregnancy. As the duration of the pregnancy increases, the center of gravity changes. A lordotic posture compensates for this somewhat, but also increases strain on the lower back. Hormonal changes make joints and ligaments more lax. Synovial fluid increases and joint space widens. The increase in joint mobility, along with an increase in body weight may make certain physical activities such as skiing, tennis and gymnastics more difficult. Sports, though, which do not require a rapid change in direction, balance and muscle strength, such as swimming, may not be adversely affected (13).

Cardiovascular changes during pregnancy also include exercise capacity. Blood volume increases by 40%-50% and resting heart rate also increases. These factors may make exercise seem more strenuous. Maternal dyspnea may occur with less exertion because of superimposition of hyperventilation of exercise on a baseline increased ventilatory rate (13). Cardiac dilatation and decreased venous return due to uterine compression make the supine position a poor choice for exercise.

Recommendations for exercise include water exercises or use of a stationary device to avoid injury. Exercising in water will also avoid a potential increase in core temperature. The heat generated by muscle activity is quickly dissipated, and animal studies have suggested that increased core temperature over 39°C may be teratogenic and result in neural tube defects. Exercising on a submerged stationary bike has also been reported to improve peripheral edema and hypertension. Edema is likely decreased because of hydrostatic pressure influences, but the mechanism of improvement in hypertension is not known.

Due to concern about fetal compromise, maternal heart rate should not exceed 140 beats per minute. The duration of strenuous activity should not exceed 15 minutes. Women should be educated to check for uterine contractions during exercise. If uterine contractions occur, exercise should be stopped. Any unusual symptoms in the mother or change in fetal movements should also result in cessation of exercise and medical consultation.

Perinatal complications

All patients with gestational diabetes are at a significant risk for fetal complications. Macrosomia, hypoglycemia, hypocalcemia, polycythemia, and hyperbilirubinemia are the most frequent.

Macrosomia has been variously defined (14). Large for gestational age is one definition, another is a birthweight of 4,000 gms or more. Other definitions include a ponderal index ($wt/\sqrt[3]{length}$) and birth symmetry index which relates weight and length to a normal cohort.

The increase in body weight of the fetus of a mother with gestational diabetes is altered in distribution. Head circumference is smaller, but shoulder and abdominal circumferences are larger. This may in part be due to increased liver size, but also is similar to the increased abdominal girth seen in Type II (non-insulin dependent) diabetics. Type II adult diabetics and these macrosomic infants also share hyperinsulinemia. Other factors associated with macrosomia are maternal obesity, excess weight gain during pregnancy and increased maternal age and parity.

In one study (15), the women with only one abnormal value on the glucose tolerance test were more likely to have an infant with macrosomia than women with all normal values. An infant with a disproportionately large trunk to head ratio may be more difficult to deliver vaginally than an infant of similar weight which is normally distributed. Shoulder dystocia and brachial plexus injury may occur, so Cesarean delivery is sometimes performed to eliminate these concerns.

Another study has suggested that it is important to administer insulin to the mother, despite normal glucose levels (16). In the patients where there were similiar glucose levels, the group receiving insulin had fewer macrosomic infants. Others have reported similar improvement with diet alone.

Various complications were noted in an Israeli study of pregnancies occurring from 1980-89 (17). Gestational diabetes was present in 878 patients, 380 were matched controls. Macrosomia was noted in 17.9% of the diabetic pregnancies compared to 5.6% of the control subjects. Glucose less than

30 mg/dl for the first 72 hours occurred in 5% of infants of diabetics. This is believed to be due to B-cell hyperplasia from fetal hyperglycemia during pregnancy.

Further results from this study revealed elevated bilirubin in 16.5% of the diabetic pregnancies compared to 8.2% controls. This was also related to maternal hyperglycemia. Since regulation of placental vascular contraction following hypoxemia is altered in hyperglycemic women (18), this may cause fetal hypoxemia and polycythemia. Polycythemia was present in 13.3% of the diabetic patients compared to 4.7% in the control subjects. Major congenital abnormalities were statistically more common in the diabetics, 3% compared to 1.8%.

Prevention

The prevention of gestational diabetes is important because it is a predictor for future development of non-insulin dependent diabetes; it is expensive; and it is associated with childhood obesity.

Depending on the criteria used for diagnosis of gestional diabetes, the population, the length of follow-up, and the number of subjects, the chances of developing either diabetes or abnormal glucose tolerance again may range from 19% to 87%. From 6%-62% will develop frank diabetes. Rates are higher with longer follow-up; lower if those who become normal postpartum are excluded (19,20).

The financial costs of gestational diabetes are very great. It has been estimated (21) that if the incidence of diabetes is reduced by 10%, that $32 million could be saved over 10 years; if it is decreased by 50% then $331 million would be saved. These calculations estimate the annual health care cost for a diabetic woman to be $2,834. The majority of these costs are probably due to the complications which occur in older people who have had diabetes for a prolonged period. The potential savings would likely not be immediately realized because there would probably be an immediate increase in cost due to nutritional and exercise counseling and periodic glucose monitoring. However, it is likely substantial savings would occur if diabetes is prevented or delayed.

Follow-up studies of offspring of diabetic mothers have been conducted to show the association of gestational diabetes to childhood obesity (22). Amniotic fluid or cord blood insulin levels have been positively related to obesity especially with an abdominal distribution. This suggests that in utero exposure to hyperinsulinemia predisposed the infant to development of future obesity.

Prevention of gestational diabetes or tight metabolic control of glucose during pregnancy may result in a lower fetal insulin level which may decrease childhood obesity. This is important because obese children are more likely than normal weight children to become obese adults with associated disorders.

Conclusion

Women with gestational diabetes are an important group to target with specific diet and exercise counseling after termination of the pregnancy in order to prevent future development of diabetes (23). Primary care providers, rather than obstetricians, should play a significant role in this area by making it a part of their evaluation of women who may be considering having children. Prevention of obesity and improved physical fitness in these women should be stressed in order to decrease the likelihood of development of diabetes.

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President's Page

Whither health care reform?

It is amazing! One of the nation's most pressing problems (at least according to all the press coverage it has received), the "health care crisis," has miraculously disappeared. Praise the Lord!

What could possibly have brought about this amazing feat? Certainly not the Clinton health care plan (thank goodness). It must be some mysterious hidden force that has solved this nation's health care woes...NOT!!

The fact remains that many of the problems that existed previously in our health care system are very much still present, but now they are compounded by an ever increasing *private* bureaucracy far worse than anything the government could have concocted. As you can see, the current trend toward managed care is driven by what we, the physicians, have historically be accused of...GREED!

While I hardly know one physician who entered this distinguished profession only for the money (most of us have this funny notion that it is noble and important to heal the sick), I have more than a sneaking suspicion that many insurance companies, managed care organizations and for-profit hospital corporations are more than a little driven by the almighty dollar. And somehow, mostly by their actions and words, I don't think they care about our patients or the quality of care they receive. These groups have no business being involved in patient care.

Left unsolved is the perplexing number of problems that were present in our health care system before this transformation, none of which the corporatization of health care attempts to solve. There are a large number of Americans with little or no health insurance. These are both individuals who can't afford it and those who can't obtain it due to "pre-existing conditions" (who thought that up anyway, you never hear of someone being denied home-owner's insurance due to a "pre-existing" condition!) all this serves to limit access to those who most desperately need it.

No one has addressed the vast amount of health care resources expended in the last few weeks of life. This and other ethical dilemmas confront us daily with no clear solutions or direction.

The U.S. Senate recently addressed the issue of product liability. Absent from the bill was any attempt at tort reform and medical malpractice, in large part at the urging of our very own junior Senator Jay Rockefeller. While defensive medicine continues to increase health care costs, the threat of being sued still haunts our dreams.

We deal with these and many other problems on a daily basis while at the same time straggling to provide quality care for our patients. Yet, we're forced to play petty payer games with the insurance companies and fight for our professional lives against health care conglomerates while our patients suffer.

It is time for physicians and responsible health care providers to examine these and other issues in an independent forum, free from government and corporate intervention, much as the Grace Commission on government waste under President Reagan. Until the parties responsible for patient care can recommend and implement responsible, common-sense solutions, we will face a constant battle between market forces and government bureaucracy that will eventually tear asunder the finest medical care system in the world over money and politics. What a shame.

In Response

While, in fact, I do abhor and detest managed care (as we all will one day), it is not for the reasons Dr. Ortenzio pointed out in his letter which is published on the opposite page.

First of all, managed care does nothing to improve access or coverage for those currently uninsured. Secondly, there is no conclusive evidence that managed care saves money in the long run, and may, in all likelihood cost more than indemnity plans. What managed care does do is interface in the traditional physician-patient relationship and rations health care to its' enrollees. I do indeed agree that preventive care is very important, but most managed care plans pay only lip service to meaningful preventive medicine as a marketing ploy.

It is true that there are many problems in our current health care system (as I have already stated in my message this month), and that physicians should be proactive in managed care systems. But, it is a fallacy perpetuated by managed care organizations that HMOs will solve these problems. For the most part, they don't even address them, and physicians rarely have significant input into their operation.

Physicians are being sold a "bill-of-goods" by these groups. It's sad they don't realize this.

– Dennis M. Burton, M.D.

Happy thoughts

The old adage, "Birds of a feather flock together," certainly holds true in the association of managed care advocates and the big government, mama-knows-best, social planners. The Clinton health care plan was, of course, labeled "managed competition" -- an oxymoron devised to disguise a federal government takeover of health care.

Since the total rout of that ill-begotten scheme, "competition" has been dropped and "managed care" has become the mantra of the same zealots previously drumming "managed competition." The set up is still the same; some benevolent person, much smarter than you, a case manager, will make all of those difficult and complicated medical decisions for you.

These kindhearted friends will tell you what doctor you should see, how often you should see that doctor or whoever might be in the office that day, whether you might be able to go to an emergency room, be admitted to a hospital, have an operation or, perhaps, just stay at home and suffer it out a bit. Oh, yes, these kindly folks, as good corporate employees, will also see to it that the company makes a buck.

Individuals are just not considered trustworthy or competent enough to manage their own affairs in the social-planner run world. Like children, we must be kept in small groups and shepherded about, lectured on what is dangerous, told what to eat, when to rest and when it is time to got to the potty.

Plans such as Medical Savings Accounts are a particular threat to the planners because under such plans, individuals are their own medical decision makers and, in association with the doctor of their own choosing, their own case managers.

The frightening part of all this for the planners is that to allow autonomy for individuals to grow and become rampant seems to eliminate the need for all the planners. What a horrible thought! Think of the unemployment in Washington and Charleston!

Come to think of it, we haven't had such a happy thought in years.

Stephen D. Ward, M.D.
Editor

Our Readers Speak

It was with great distress that I read Dr. Burton's President's Page message in the February issue of the *Journal* in which he expressed concerns about the inevitability and necessity of managed care. The take-home message from the article is "Please resist managed care because it's an evil and damaging force that will only cause deterioration of the high quality of medical care we now have in the United States and, more particularly, in West Virginia."

Dr. Burton fails to recognize the problems inherent in our present "non-system." Large factions of the population do not have consistent and dignified access to health care services. The health care system is bankrupting American business and making us non-competitive as a nation. Our system is based on negative interventions, episodic and expensive, inefficient care. Preventive care in the pursuit of health is negated. Certainly, there are very wonderful aspects of health services in the United States, but they are clearly outweighed by negative aspects.

Managed care in almost any form provides us an opportunity to systematize and streamline care to emphasize preventive medicine. Certainly, it will be painful and disruptive to put in place this rational system we call managed care, but the benefits to be achieved far outweigh any temporary inconveniences and their repercussions. Moreover, managed care is coming through natural market forces whether we want it to or not.

I believe we should be proactive and take steps to insure proper physician input and control in these new systems. We have a sacred duty to serve our society. A step short of assimilation and cooperation is a terrible mistake.

Thank you.

Louis F. Ortenzio, M.D.
Clarksburg

1995 WVSMA Annual Meeting Highlights
August 16-19

Tuesday, August 15

6 p.m.	WVSMA Executive Committee Dinner/Business Meeting

Wednesday, August 16

8 a.m.	WVSMA Executive Committee Breakfast Meeting
11:30 - 1:30 p.m.	Executive Committee/Council Luncheon
1:30 - 4:30 p.m.	WVSMA Council Meeting
6:30 - 7:30 p.m.	Presidential Reception

Thursday, August 17

7 - 8:30 a.m.	Component/Specialty Society Presidents' Breakfast
8:30 a.m. - Noon	**General Scientific Session** (Potpourri in Medicine) "Inflammatory Bowel Disease," Robert W. Beart Jr., MD "The Diagnosis of Neck Masses: Physical Diagnosis or High Technology," David E. Schuller, MD "The Medical Savings Account - How It Works," Hanley Clark, Insurance Commissioner, State of WV David E. Haden, RMI, Ltd.
Noon - 1:30 p.m.	**Lunch and Learn** (limited space) "Medical Ethics and Rationing Care," Warren Point, MD AMA President and other visiting dignitaries
2 p.m.	Golf, Tennis and Volleyball Tournaments
4 p.m.	1996 Annual Program Committee Meeting
6:30 - 7:30 p.m.	Reception

Friday, August 18

7:30 a.m.	**Breakfast Meetings** (times and locations to be announced)
8:30 a.m.	**First Session of the House of Delegates** Edmund B. Flink Address - Thomas C. Spelsburg, MD Thomas L. Harris Address - Robert W. Beart Jr., MD Presidential Address - Dennis M. Burton, MD
Noon - 1:30 p.m.	**Lunch and Learn** (limited space) "From Tort deForm to Tort Reform," Ronald Alexander Esq., JD AMA President and other visiting dignitaries
Noon	**Specialty Meetings** Various chapters of West Virginia Specialty Societies will be scheduled for luncheon/business and scientific meetings. Times and locations will be noted at a later date in the *West Virginia Medical Journal* and the official program.
1:30 p.m.	Resolutions Committee - Open Session
6 - 7 p.m.	Reception hosted by WVU/MU Schools of Medicine, WVU and MCV Alumni
8 p.m. - midnight	Outing and Entertainment on Kate's Mountain

Saturday, August 19

7:30 a.m.	**Breakfast Meetings** (times and locations to be announced)
7:30 a.m.	**Second Session of the WVSMA House of Delegates** Delegate Registration
9:00 a.m.	AMA Presidential Address - Lonnie R. Bristow, MD Resolutions Election of Officers "Health Problems of Our Presidents," Robert D. Crooks, MD
11:30 a.m. - 1:30 p.m.	WVSMA 50-Year Graduates, Past Presidents, Visiting State Presidents
1:30 p.m.	**Reconvene Second Session of House of Delegates** (business continued) Oath of Office and Presidential Address *Reception honoring newly-installed officers of WVSMA and Alliance **Time dependent upon adjournment of House of Delegates Session*

The West Virginia State Medical Association's

1995 Annual Meeting

August 16-19, 1995

Space is being held at other area hotels/motels, contact the WVSMA at 304-925-0342 for more details. For your convenience, you may call the WVSMA office and register for the conference using your Visa or MasterCard.

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1995 WVSMA Annual Meeting

August 16-19, 1995

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West Virginia State Medical Association
P.O. Box 4106
Charleston, WV 25364

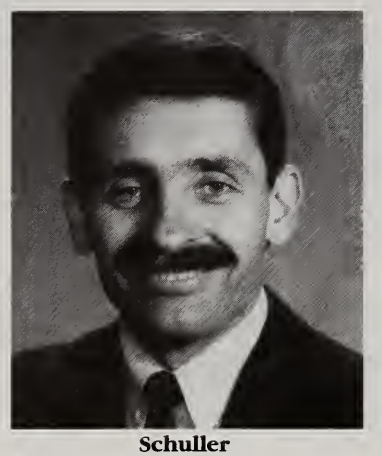
*Conference Cost:	WVSMA member	$125	_____
	non-member	$175	_____
*Lunch & Learn	(Thursday, Aug. 17)		
	physician	$50	_____
	spouse/student	$35	_____
	(Friday, Aug. 18)		
	physician	$50	_____
	spouse/student	$35	_____
*Kate's Mountain Outing/Entertainment	(Friday, Aug. 18)		_____
	couple	$100	_____
	single	$50	_____
	Deduct 10% if attending all events		_____
	TOTAL		_____

The Greenbrier will fill up quickly because the State Fair will be going on during the same week. For more information, call the WVSMA office at (304) 925-0342.

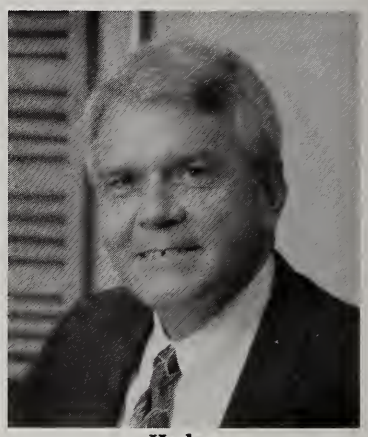
At Annual Meeting

General Session to feature topics of bowel disease, neck masses, medical savings accounts

Beart


Schuller

Clark


Haden

In order to provide participants with a variety of subjects pertaining to the continuing changes in the medical environment today, this year's General Session on Thursday, August 17 during the WVSMA's Annual Meeting at The Greenbrier, will feature scientific and health reform presentations.

This diverse session will begin with the lecture "*Inflammatory Bowel Disease/Crohn's Disease*" by **Robert W. Beart Jr., M.D.**, professor of surgery at the University of Southern California School of Medicine. Dr. Beart will also deliver this year's Thomas L. Harris Address, "*Current Management of Ulcerative Colitis,*" during the First Session of the WVSMA House of Delegates on Friday, August 18.

Following Dr. Beart's presentation, **David E. Schuller, M.D.**, professor and chair of Ohio State University's Department of Otolaryngology, who is also director of the Comprehensive Cancer Center of the Arthur G. James Cancer Hospital and Research Institute at OSU, will discuss "*The Diagnosis of Neck Masses: Physical Diagnosis or High Technology?*"

After these two lectures, the session will focus on "*The Medical Savings Account - How It Works.*" Addressing this subject will be **Hanley Clark**, insurance commissioner for the state of West Virginia, and **David E. Haden** of RMI, ltd.

Brief biographical information about these four speakers begins below, and a preliminary program for this year's WVSMA Annual Meeting appears on page 154 with a registration form on the opposite page. For more meeting information, phone the WVSMA at (304) 925-0342.

Speakers highlighted

Dr. Beart earned his medical degree at Harvard University in 1971 and then completed a two-year general surgery residency at the University of Colorado, where he also served as a transplant fellow from 1974-75.

After his fellowship, Dr. Beart stayed at the University of Colorado as chief surgery resident from 1975-76. The next year he relocated to Rochester, Minn., to serve as a transplant fellow at the Mayo Clinic. In 1979, Dr. Beart was named an assistant professor of surgery at the Mayo Clinic, and in 1984, he was elevated to associate professor status.

Three years later, Dr. Beart became a full professor and served for a year as the Caywood Professor of Surgery at Mayo. Dr. Beart worked at Mayo until 1992, when he accepted his current posts as professor of surgery and professor colon and rectal surgery at the University of Southern California.

A former president of the American Society of Colon and Rectal Surgeons, Dr. Beart also recently served on the American College of Surgeons' Commission on Cancer and the Colon and Rectal Advisory Committee of the American Cancer Society. Dr. Beart has co-edited two books and published over 250 chapters and articles, as well been an assistant editor for *Geriatrics* and *Diseases of the Colon and Rectum.*

Dr. Schuller graduated with honors from the Ohio State University College of Medicine, and has held head and neck surgical oncology fellowships at The Pack Medical Foundation with Dr. John Conley in New York City and at the University of Iowa.

Dr. Schuller is now director of the Comprehensive Cancer Center at the Arthur G. James Cancer Hospital and Research Institute at OSU, and directs the Comprehensive Cancer Center Head and Neck Oncology Program. He also is professor and chair of the Department of Otolaryngology at the OSU College of Medicine and is a professor in the School of Allied Medical Professions.

A specialist in head and neck surgery, as well as facial plastic and reconstructive surgery, Dr. Schuller has served as director of the American Board of Otolaryngology, and as a professor of clinical oncology for the American Cancer Society.

Instrumental in creating the National Cancer Institute Head and Neck Intergroup, Dr. Schuller served as chair from 1986-89. He has also been chair of the Head and Neck Committee of the Southwest Oncology Group since 1983.

During his career, Dr. Schuller has received numerous honors including the Edmund Prince Fowler Award of The Triology Society. He was listed in *Good Housekeeping's* article *"The Best Cancer Specialists in the USA* and Woodward/White's *"The Best Doctors in America."* He is the author of over 150 articles and book chapters, and is the editor or author of five textbooks.

Mr. Clark entered state government as special assistant to John D. Rockefeller IV in 1980, and served in that post until March 1981 when he was named the assistant to former Insurance Commissioner Richard G. Shaw.

In March 1985, Mr. Clark became deputy insurance commissioner. He then was named acting insurance commissioner when Commissioner Wright resigned to become director of the PEIA. Mr. Clark held this position from July 1, 1988 until January 18, 1989, when Governor Caperton appointed him insurance commissioner.

A Huntington native, Mr. Clark received his bachelor's degree from Marshall University in 1972 with a major in history and a minor in English and business. He graduated from WVU in 1974 with an M.A. in history. Upon completion of his dissertation, Commissioner Clark will have a Ph.D. in university administration.

Mr. Haden was born in Huntington and began his business career at Standard Food Service where he attained the position of sales manager. Since 1973, he has worked in the insurance business, specializing in professional liability and group health.

In 1987, Mr. Haden created RMI, ltd to combine his existing business with that of another agency. Currently, RMI is affiliated with National Merit Benefit Partners, a national consortium of specialty firms which creates and designs plans for executives and employee benefit programs.

Mr. Haden is a life and qualifying member of the Million Dollar Round Table. He has written articles on self-funded health plans and has spoken at several national meetings.

Medical ethics, tort reform topics for Lunch & Learns

Two of the popular Lunch and Learn events which offer education in conjunction with a luncheon are scheduled for this year's WVSMA Annual Meeting at The Greenbrier.

"Medical Ethics and Rationing Care," is the title of the first Lunch and Learn, which will be presented by **Warren Point III, M.D.**, of Charleston, on Thursday, August 17 from noon - 1:30 p.m. Joining Dr. Point for this discussion will be **AMA President Dr. Lonnie R. Bristow**; **Dr. Robert G. Goodin**, president of the Kentucky Medical Association; **Dr. Jack L. Summers**, president of the Ohio State Medical Association; and **Russell D. Evett**, president of the Medical Society of Virginia.

The following day at noon, the second Lunch and Learn, *"From Tort deForm to Tort Reform,"* will be conducted by **Ronald Alexander, Esq., JD.**, of Munroe Falls, Ohio. Mr. Alexander will also be joined by **Drs. Bristow, Goodin, Summers, Evett,** as well as **Dr. William Cooper**, president of the Indiana State Medical Association; **George S. Malouf, M.D.**, past president of the Maryland Medical Society; and **Dr. John H. Hobart**, president of the Pennsylvania Medical Society.

Dr. Point received his M.D. degree from Harvard University in 1945. He completed his internship and had started his residency at Boston City Hospital when he joined the Army and earned the rank of captain.

After his military service, Dr. Point completed his residency at Boston City Hospital and became a clinical and research fellow in gastroenterology at Massachusetts General Hospital, where he remained on staff to practice internal medicine and gastroenterology until 1977. During these years, he also held faculty positions at Harvard and MIT.

In 1977, Dr. Point returned to his hometown of Charleston to join his current practice in internal medicine and gastroenterology at WVU's Charleston Division's. He is a professor emeritus at the WVU School of Medicine, where he was a professor of medicine 13 years and received honors as Teacher of the Year twice and was named Clinician of the Year in 1987.

A member of many professional organizations, Dr. Point is a fellow and a former governor of the American College of Physicians and serves on the WVSMA's Medical Education Committee. Known also for his involvement in the local community, Dr. Point serves on the boards of trustees for the CAMC Foundation, the University of Charleston and the Charleston National Bank.

Mr. Alexander received his B.A. and J.D. degrees from the Ohio State University College of Law, and his LL.M. from the University of Pennsylvania College of Law, where he became a fellow at the school's Center for the Study of Financial Institutions, Wharton School of Business.

(Continued on next page)

Point

Alexander

Lunch & Learn cont.

Following his fellowship, Mr. Alexander was a law professor at the University of Akron College of Law for 10 years. He is currently an adjunct professor on the faculties of both the Ohio University College of Osteopathic Medicine and Northeastern Ohio Universities College of Medicine, and is a charter member of the faculty of Ohio State University's renowned Academy for Financial Executives.

Mr. Alexander is a director on the boards of two savings and loan associations and the board of a savings and loan holding company. He also serves as a trustee on the board of the Foundation of the Northeastern Ohio Universities College of Medicine.

After many years of practice in large regional and national law firms, Mr. Alexander is now a solo practitioner in Monroe Falls, Ohio. He represents various health care providers, including hospitals, physicians, medical staffs, ambulance companies, and DME companies in contract, reimbursement, managed care, credentialing and other health law matters.

HCFA promoting Medicare's benefits on mammography

The Health Care Financing Administration (HCFA) has launched a consumer and provider campaign to promote awareness of Medicare's mammography benefits. Screening mammograms became a Medicare-covered benefit on January 1, 1991.

Despite the high incidence and mortality of breast cancer among elderly women, recent Medicare claims indicate that fewer than 7 million (less than 40%) of 18 million female Medicare beneficiaries age 65 or older received a diagnostic or screening mammogram during the past two years. This means that nearly 10 million female Medicare beneficiaries age 65 or older are potential candidates for mammograms. The Department of Health and Human Services Year 2000 Goal is to increase the number of older women who receive screening mammograms every 24 months to 60% of the eligible population.

HCFA will work with physicians to encourage female beneficiaries to obtain regular mammograms, in addition to clinical breast exams.

At Annual Meeting

Don't miss out on the music, food, fun at Kate's Mountain!

The scenic Kate's Mountain area at The Greenbrier will be the setting for a special casual evening of entertainment featuring Cajun musician Waylon Thibodeaux on Friday, August 18 at this year's WVSMA Annual Meeting. A buffet dinner will be offered for guests.

Thibodeaux is a French-speaking Cajun who performs a variety of Louisiana, Cajun and Zydeco music. Known as Louisiana's Rockin' Fiddler, Thibodeaux began playing professionally at age 13. He has performed with nationally and internationally renowned musicians and groups such as Tony Orlando, Jo-El Sonnier, Jimmy C. Newman, BeauSoleil and Evangeline, and is a artist with Mardi Gras Records. In addition to playing at festivals and special events in the U.S. and Canada, Thibodeaux is a popular act at La Strada's Nightclub in New Orleans.

Thibodeaux

The cost for the evening is $100 a couple or $50 for a single guest.

To register for this event and the WVSMA's Annual Meeting, turn to page 155 or phone the WVSMA at (304) 925-0342.

Don't Delay . . . Register Today!!!

WVSMA's 128th Annual Meeting
August 16-19
The Greenbrier
White Sulphur Springs, WV

Turn to Page 155 or phone the WVSMA at (304) 925-0342

Research Day winners

The individuals who received honors at the annual Research Day competition sponsored by the Charleston Division of the Robert C. Byrd Health Sciences Center of WVU and CAMC were (standing) Anita M. Guerriero, M.D.; Bryan K. Richmond, M.D.; Kapriel Danadian, M.D.; and (seated) Heather L. Mertz, MSIV; Samuel E. Brown, M.D., and Nelson H. Lo, M.D. Mertz received first place in the original research category; Dr. Brown won second place; and Dr. Lo won third place in this category. Dr. Guerriero placed first in the case study presentations, with Dr. Richmond placing second; and Dr. Danadian winning third-place honors.

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Service That Stands Out

CAMC approved to continue efforts for breast cancer trial

The Charleston Area Medical Center has been approved to continue its efforts to accrue eligible area women to the National Surgical Breast and Bowel Project (NSABP) Breast Cancer Prevention Trial, sponsored by the National Cancer Institute.

CAMC has recently been successful in completing the required audit procedures for both institutions and again offers a unique opportunity for physicians in the state to be a part of a project which could help identify a substance effective in preventing breast cancer in women at high risk for developing the disease. This double-blind study will determine whether long-term tamoxifen therapy lowers the incidence of fatal and non-fatal myocardial infarction and reduces the incidence of bone fractures. Steven J. Jubelirer, M.D., is the principal investigator for the study.

The subcenter for the BCPT in West Virginia is the Mary Babb Randolph Cancer Center in Morgantown. The subcenter's investigator is Edward Crowell, M.D., and the coordinator is Sharon Fritchnar, R.N., B.S.N.

Women who have had invasive breast cancer may not participate in this study, but their female blood relatives may well be candidates. Health care professionals or interested women may call CAMC's BCPT office at 348-4337 or Mary Babb Randolph Cancer Center's BCPT office at 293-3575.

Leukemia Society, Arthritis Foundation offer toll-free hotlines

The Leukemia Society of America and the Arthritis Foundation both operate toll-free information resource lines to help patients, their families, the public and medical professionals receive free information and brochures.

The Leukemia Society of America can be reached at (800) 955-4LSA, and the Arthritis Foundation's phone number is (800) 283-7800.

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state and region. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your organization for physicians printed in the *Journal*, please contact Nancy Hill, managing editor, at 925-0342.

Charleston Area Medical Center - Charleston

May 23
Pediatrics Advanced Life Support Recertification Course (Advance Registration Required)

June 1
(Teleconference) "Interdisciplinary Approach to Cesarean Birth Reduction," Norman B. Duerbeck, M.D.; Randall J. Hill, M.D.; Robert T. Westmoreland, M.D.; and Paul Vasale, R.N.C., B.S.N., C.E.S.

June 6
"Intera-aortic Balloon Pump"

June 15
(Teleconference) "Development Outcomes of the High Risk Infant," Holly Cloonan, Ph.D., and Lori Butch, P.T.

Huntington Medical Community Foundation - Huntington

June 14
"Coronary Artery Disease: Surgical Treatment," John Dae Harrah, M.D., The Brass Tree Restaurant, Williamson, 6:30 p.m.

June 15
"Culture in the Health Care Environment," Reverend Gary Patton, Logan General Hospital, Logan, noon

June 27
"Pharmacokinetics," Rob Staton, Pharm.D., Williamson Appalachian Regional Hospital, South Williamson, Ky., 5:30 p.m.

July 20
"Evaluation and Treatment of Chronic Back Pain," David L. Weinsweig, M.D., Pleasant Valley Hospital, Pt. Pleasant, noon

Marshall University School of Medicine - Huntington

June 19
"Overview on Hematological Malignancies," Kenneth Miller, M.D., of Boston, Radisson Hotel, 6:30 p.m.

June 20
"Non Hodgkin's Lymphoma," Kenneth Miller, M.D., of Boston, St. Mary's Hospital, 8 a.m.

"Chronic Myelogenous Leukemia," Kenneth Miller, M.D., of Boston, Huntington Internal Medicine Group, 1115 20th Street, 12:30 p.m.

Robert C. Byrd Health Sciences Center of WVU - Morgantown

May 25
"Third Annual Antonio Palladino Memorial Lectureship and Residents' Research Presentations" (sponsored by the WVU Dept. of Obstetrics and Gynecology)

June 1 - 3
"Community Wellness '95" (sponsored by the WVU Office of Community and Continuing Professional Education

June 9
"The Ethics of Managed Care" (sponsored by the Center for Health Ethics and Law, and the WV Network of Ethics Committees)

June 19 - August 11
"Health and Medicine in the Tropics (sponsored by the WVU Program in International Health, Section of Infectious Diseases, and the Dept. of Microbiology)

West Virginia State Medical Association - Charleston

August 16-19
"WVSMA's 128th Annual Meeting," The Greenbrier, White Sulphur Springs

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *Charleston Area Medical Center, Charleston*

Fairmont ★ Fairmont Clinic, June 21, 1 p.m., "AIDS," R. Wesley Farr, M.D.

★ Fairmont General Hospital, June 13, 7 p.m., "Conscious Sedation," John Barbaccia, M.D.

Montgomery ☐ Montgomery General Hospital, June 7, 12:30 p.m., TBA

New Martinsville ★ Wetzel County Hospital, June 8, noon, "Cardiac Tumors" Jaimela Dulaney, M.D.

Ripley ☐ Jackson General Hospital, June 9, 12:30 p.m., TBA

White Sulphur Springs ★ The Greenbrier Clinic, June 26, 4 p.m., "Adult Immunizations," R. Wesley Farr, M.D.

**TBA - To Be Announced*

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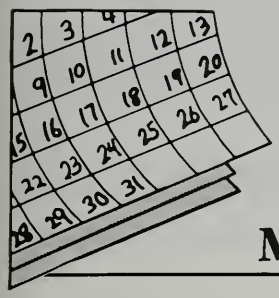


Medical Meetings

June

2-3–Using Data to Improve Quality in Healthcare (sponsored by National Association for Healthcare), Cleveland

7-9–Third International Symposium on Maritime Health (sponsored by George Washington University), Baltimore

7-9–First Russian-American Breast Cancer Conference (sponsored by National Cancer Institute), Saratov, Russia

7-10–2nd Annual Intensive Review of Internal Medicine (sponsored by George Washington University), Washington, D.C.

8-10–Geriatric Medicine: An Update on Diagnosis and Management (sponsored by SMA), San Antonio

8-10–North American Stroke Meeting (sponsored by National Stroke Association), Denver

8-13–American Diabetes Association, Atlanta

11-15–19th Annual Lung Symposium (sponsored by SMA), Sea Island, Ga.

16-18–Musculosketal Problems in Primary Care (sponsored by SMA), Kiawah Island, S.C.

17-21–17th National Lesbian and Gay Health Conference and 13th Annual AIDS/HIV Forum (sponsored by George Washington University), Minneapolis

21-25–American Holistic Medical Association, Phoenix

22-25–American Congress of Rehabilitation Medicine, Arlington, Va.

23-25–Practicing Preventive Medicine in the 90s (sponsored by SMA), Berkeley Springs, W.Va.

24-28–3rd Annual Board Review in Family Medicine (sponsored by George Washington University), Arlington, Va.

29-July 2–13th Annual American Association of Physicians from India, Chicago

July

2-4–25th Annual Sports Medicine Symposium (sponsored by North Carolina Medical Society), Atlantic Beach, N.C.

6-8–1995 Annual Meeting of the Southern Orthopaedic Association, Quebec City, Quebec, Canada

13-15–7th Annual Meeting of the American In-Vitro Allergy/Immunology Society

14-16–What's Hot in Primary Care (sponsored by SMA), Palm Beach, Fla.

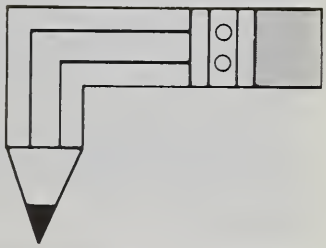
24-26–General Surgery Update (sponsored by SMA), Sea Island, Ga.

24-27–Focus on the Female Patient (sponsored by SMA), Kiawah Island, S.C.

28-30–Focus on the Male Patient (sponsored by SMA), Kiawah Island, S.C.

For More Information . . .
Contact the Journal at (304) 925-0342.

Poetry Corner



Upbeat Platitudes

Concerning those who look at life
with nothing but an attitude
of negativity and gloom,
believing that a time of doom
awaits them just around the turn
and will o'ertake them down the road,
to them we say, "Lighten your load!"
We see the weight which burdens them
and know they cannot carry it
without depressive interludes.
We sometimes speak in platitudes;
but in this case that may be good.
We need to tell them, "Be upbeat.
It's darkest just before the dawn,
and soon your troubles will be gone.
Be positive in all you do.
Don't let your troubles get you down.
Believe that there are those who care.
Keep up your spirits; don't despair."

E. Leon Linger, M.D.

Gone Fishin'

There is a poem I'll never write.
Feelings transposed to words
Might have been
Had I not, at that very instant,
Started reeling in
My line, responding to a fish's bite.

The serenity, the magic
Of the moment, shattered
To reality, as if it mattered
More to land a fish
Than satisfy the wish
To record for my posterity
The peace and beauty
I had glimpsed, albeit momentarily.

Robert L. Smith, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Bureau for Public Health News

This page of material is submitted and paid for by the Bureau for Public Health.

Vital statistics report released for 1993

West Virginia's population grew in 1993 for the third year in a row, according to the *1993 West Virginia Vital Statistics* which was recently published. Of this increase of about 11,000, 1,462 individuals were due to natural increase (or the occurrence of more births than deaths), and the rest was the result of in-migration.

The number of births in 1993 was 21,793, a decrease of 363 births from 1992. Births to teens, though, increased to 3,827 in 1993, from 3,809 in 1992. The percentage of births to unmarried teens also continued to increase, from 57% in 1992 to 60% in 1993.

Seventy-six percent of West Virginia mothers began prenatal care during the first trimester of pregnancy, but 26% of women giving birth in 1993 smoked and 1.5% drank alcohol during their pregnancy. Twenty-five percent of the children born in 1993 were delivered by Cesarean section, compared to a national rate of 22% in 1992.

State deaths increased in 1993 to 20,331, from 19,696 in 1992. Average age of death was 68.5 years old for men, 75.3 years old for women. Deaths due to heart disease, cancer and stroke all increased, and were the leading causes of death. In fact, the state mortality rate in 1993 for heart disease was 19% higher than the national average, the rate for cancer was 10% higher, and the rate for stroke was 2% higher.

Even larger differences were noted for deaths due to chronic obstructive pulmonary disease (31% higher), unintentional injuries (40% higher), and diabetes (26% higher). The suicide rate increased to 267 in 1993, from 244 in 1992; and 79% of all suicide deaths in were firearm related. In addition, there were again 135 homicide deaths in the state, and 70% of these were due to firearms.

Infant deaths decreased to 187 in 1993, from 201 in 1992, with an overall infant mortality rate of 8.6 deaths per 1,000 live births in 1993, compared to 9.1 in 1992. The white infant mortality rate decreased 9% from 1992 to 1993, from 8.9 to 8.1, while the mortality rate for black infants increased from 12.3 in 1992 to 20.8 in 1993.

The report also includes a trivia page, that shows the most deaths in 1993 occurred on March 13 and December 31, while the most births occurred on December 21. In other trivia, the most popular names for boy babies were: Tyler, Michael, Joshua, Brandon, and Cody; the most popular girls' names were Ashley, Brittany, Jessica, Kayla, and Samantha.

For a copy of the *1993 West Virginia Vital Statistics*, phone (304) 558-9100.

Clean indoor air regs in effect in 15 counties

Residents in 15 West Virginia counties are now being protected from secondhand smoke, thanks to the actions of their boards of health to pass clean indoor air regulations.

Cabell County is the latest county to enact a clean indoor air policy to restrict smoking in many public areas. The other counties with similiar laws are Calhoun, Grant, Hampshire, Kanawha, Marion, Monongalia, Pleasants, Pendleton, Raleigh, Randolph, Ritchie, Roane, Wirt, and Wood. The cities of Belmont, Bluefield, Fairmont, Morgantown and Princeton, have also passed smoking regulations.

Secondhand smoke is a mixture of the smoke given off by the burning end of a cigarette, or cigar, and the smoke exhaled from the lungs of smokers. This mixture of over 4,000 substances contains more than 40 carcinogens known to cause cancer in humans. The EPA estimates that, nationwide, secondhand smoking is responsible for 3,000 lung cancer deaths in nonsmokers, annually; and that between 150,000 and 300,000 lower respiratory tract infections in children under the age of 18 months are attributed to secondhand smoke.

For more details on secondhand smoking or clean indoor air regulations, call the Bureau's Tobacco Control Program at (304) 558-0644.

Health report looks at effects of lifestyles

According to the 1993 Behavioral Risk Factor Survey, West Virginians are wearing seatbelts more often and drinking less alcohol than people from most other states, but our citizens continue to have the second highest rate of obesity in the nation, behind only Mississippi.

The survey indicated that the percentage of adults in West Virginia who didn't use seatbelts regularly decreased from 40% in 1992 to 31% in 1993. Non-use of seatbelts dropped dramatically after the state's seatbelt law took effect in September 1993.

Regarding alcohol use, the survey states that West Virginians continue to report some of the lowest rates of alcohol misuse in the country. In 1993, only 2% reported having more than 60 drinks in the previous month, only 7% reported having had at least five drinks on a single occasion, and only 1% reported drinking and driving. These statistics rank the state 42nd, 49th and 44th, respectively in those categories.

The 1993 report gives special emphasis to the problem of obesity. Although it is increasing nationally as well, obesity is especially high in West Virginia. In 1993, 36% of the adults in the state were at least 20% over their ideal weight.

For the last five years combined, higher rates of obesity were found among blacks, men with higher income, and women with lower education and income. Married people had a higher rate of obesity than individuals who were divorced or single. Obese adults were less likely than appropriate-weight adults to report using seatbelts and were more likely to report having high blood pressure, high cholesterol, and diabetes. Smoking, however, was less commonly reported among the obese. Although obese people rate their own health worse than do appropriate-weight people, only about half are making an effort to lose weight.

To receive a copy of the 1993 Behavioral Risk Factor Survey, call the Bureau's Office of Epidemiology and Health Promotion at (304) 558-9100.

If the U.S. Senate Can Deliver Health Care Liability Reform, Maureen O'Regan Can Deliver Babies Anywhere.

Meet Dr. Maureen O'Regan.

She's an obstetrician in northern Virginia, within sight of the nation's Capitol.

She delivers babies in Virginia where there's a limit on health care liability awards.

Just across the Potomac River, in Washington, D.C., there is no limit, and malpractice insurance costs at least $68,000 – more than twice the cost in Virginia.

Dr. O'Regan would like to deliver babies in Washington, but the cost is too high and the risk is too great.

She's not alone. One out of eight obstetrician/ gynecologists nationally no longer delivers babies. Other doctors all across the country struggle with the same dilemma.

Without liability caps, huge amounts of money are spent on defensive medicine. Physicians must order more procedures and tests than the patient really needs. The trust between patient and physician is threatened.

Congress can fix this. The U.S. House of Representatives has already passed a bill that would set a $250,000 cap on noneconomic damages. Now it's up to the U.S. Senate.

Contact your U.S. Senators **now**. Tell them to vote for Health Care Liability Reform.

And let Dr. O'Regan deliver babies wherever she's needed.

*Write **both** U.S. Senators c/o U.S. Senate, Washington, D.C. 20510. Or call their offices at (202) 224-3121.*

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OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

Spratto named new dean of pharmacy

Spratto

Effective July 1, George R. Spratto, Ph.D., has been named dean of the School of Pharmacy.

Dr. Spratto is one of the authors of *"The Nurse's Drug Handbook,"* a standard annual reference tool for nurses and nursing students. He has been associated with the handbook since it was first printed by Delmar Publishing Company in 1977. He is also an author of the annual publication *"Nurses' Drug Reference."*

Dr. Spratto is associate dean for professional programs at the School of Pharmacy and Pharmacal Sciences at Purdue University. He also serves as an adjunct professor of pharmacology at the Indiana University School of Medicine. Prior to these posts, Dr. Spratto was a pharmacologist at the Bureau of Drug Abuse Control of the FDA in Washington, D.C.

A native of Connecticut, Dr. Spratto is a graduate of the Fordham University College of Pharmacy. He completed postgraduate training in pharmacology at the University of Wisconsin and the University of Minnesota.

Fellow wins first place

Dr. Margaret Jaynes, fellow in pediatric neurology, won first place for her resident presentation, *"The Normal Plantar Response in Normal Newborn Infants"* at the Southern Pediatric Neurology Society's annual meeting in New Orleans.

The paper was co-authored by Dr. John Bodensteiner, professor and section chief; Dr. Monique Gingold, resident; Ashley Hupp, MSII, pediatric neurology; and Dr. Martha Mullett, professor of neonatology.

Fidler named to AAP president-elect post

Fidler

Dr. Donald Fidler, associate professor of psychiatry, was recently elected president-elect of the Association of Academic Psychiatry at the organization's national meeting in San Antonio, Texas on March 15.

Majority of grads to enter primary care

For the second year in a row, more than 60 percent of the graduating class from the WVU School of Medicine have been accepted into residency programs in primary care.

This summer, 82 students from the Class of '95 will start postgraduate training, and 20% have chosen internal medicine residencies, with 15% selecting family medicine. Other primary care residencies chosen included ob/gyn 10%; pediatrics 10%; medicine/pediatrics 6%; and medicine/psychiatry 2%. A total of 51 of the students, 62% of the class, are entering primary care training programs.

The six med students participating in the Kellogg program were accepted into primary care residencies.

HSC receives grant for technology academy

The Kellogg Foundation has awarded the Health Sciences Center $1,999,624 for its Health Sciences and Technology Academy (HSTA). The academy is a series of programs that encourages students to pursue careers in the health sciences.

Last year, the academy worked with students and teachers from McDowell and Kanawha counties. This year, the program will expand into Greenbrier, Monroe, Braxton, Webster, Roane, Calhoun, Marshall, Ohio and Fayette counties.

Ducatman assists with DOE medical project

Ducatman

Dr. Alan Ducatman, professor and director of the Institute of Occupational and Environmental Health, attended the recent meeting of the U.S. Department of Energy (DOE) to help design a congressionally mandated medical surveillance program for nearly 200,000 retired DOE workers.

Junior high students to participate in seminar

The WVU Center for Black Culture and Research will host a seminar from July 28-29 to introduce the state's seventh, eighth and ninth graders to health sciences careers. Minority and socioeconomically disadvantaged students, and those with strong interests in math and sciences are encouraged to participate.

For more details, phone 293-7029.

Emergency medicine profs deliver abstracts

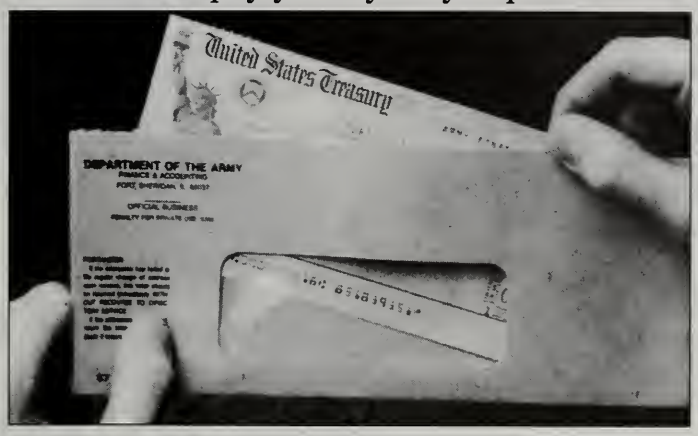
Dr. Janet Williams and Dr. Rosanna Sikora, assistant professors of emergency medicine, presented abstracts at the Child and Adolescent Rural Injury Control Conference held in Madison, Wisc., from March 8-9.

Dr. William's abstract was entitled *"Pediatric Intentional Injuries in Rural Appalachia"* and Dr. Sikora's abstract was titled *"The Epidemiology of Childhood Injury in Rural Appalachia Using an Emergency Department Injury Surveillance System."*

In addition, Dr. William Ramsey, another assistant EM professor, presented *"Telemedicine for Emergency Physicians"* at the American College of Emergency Physicians Winter Symposium in Ft. Lauderdale, Fla.

SURGEONS: COULD YOU USE AN EXTRA $10,000?

If you're a resident in surgery, the Army Reserve will pay you a yearly stipend which could total in excess of $10,000 in the Army Reserve's Specialized Training Assistance Program (STRAP).



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Marshall University School of Medicine

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

MU awarded funds to implement innovative preclinical curricula

Marshall University has received a three-year, $300,000 award to implement innovative preclinical curricula through the Interdisciplinary Generalist Curriculum Project, which is a project of the Primary Care Organizations Consortium.

Building on a pilot program that was introduced last fall, Marshall will implement a core generalist curriculum called Introduction to Patient Care that will span the first two years of the medical curriculum.

The core curriculum will lay the foundation of knowledge, skills and attitudes necessary for primary patient care utilizing the following principal components:

- A fund of knowledge of health promotion, disease prevention and common illnesses;
- Longitudinal patient experience with mentors in ambulatory settings; and
- Skills for gathering information from patients.

The core curriculum will integrate the content of the clinical courses around the concept of continuity of care, institute a "critical inquiry" learning process, and provide for ambulatory care experience with physician mentors. Clinical course directors for each semester will jointly plan their courses so that for each topic the natural history and management of disease, psychosocial well-being and prevention is addressed.

The set of health risks and illnesses that will be addressed has been created by combining the list of leading causes of death and the health problems identified in the Guide to Clinical Preventive Services produced by the U.S. Preventive Services Task Force.

In addition to implementing the core generalist curriculum, the project will establish a Generalist Education Resource Center and provide faculty development opportunities for teaching faculty and mentors.

The project director is Dr. Patricia Kelly, associate professor of pediatrics, and the co-directors are Dr. Sarah McCarty, associate professor of internal medicine, and Dr. Linda Savory, professor of family and community health. Funding for the project comes from the U.S. Health Resources and Services Administration.

Research Day honors awarded to eight students, residents

Eight students and residents received awards for outstanding presentations at the School of Medicine's Research Day.

In basic sciences presentations, the winners and their projects were:

Kristy A. Blankenship
"Stimulation of c-myc expression in T47D human breast cancer cell line upon treatment with progestins"

Suk Kil Hong
"In vivo and in vitro renal effects induced by N-(3,5-dichlorophenyl) 2-hydroxysuccinimide-O-sulfate (NSC), a putative metabolite of n-(3,5-dichlorophenyl)succinimide (NDPS)"

Greg S. Larsen
"Activities of tarsal afferents in freely walking cockroaches"

The following individuals won clinical case presentation awards:

Brian Francis
"Epidural hematoma and neurologic sequelae as a complication of thrombolytic therapy for acute myocardial infarction"

Linda G. Brown
"Primitive peripheral neuroectodermal tumor"

The three individuals selected for the Lester Bryant Award this year were as follows:

Todd Gress
"Infection with moderately resistant streptococcus pneumoniae does not alter clinical outcome"

Joan B. Lehmann
"Chest pain in the emergency department: Is there a gender bias"

Mohammad Wasay
"Senile gait or ischemic gait?"

Consultants for rural geriatrics project receive AOTA award

For their work in pioneering a rural practice model for occupational therapy, Vivian Maggard, COTA/L, and Sharon Pape, OTR/L, of the Department of Psychiatry recently received the Terry Brittell COTA/OTR Partnership Award of the American Occupational Therapy Association. The two were team consultants for Marshall's rural geriatrics project in Lincoln County, and serve patients in a variety of underserved settings.

Elizabeth Devereaux, who retired from MU last year, received the 1995 Meritorious Service Award and Honorary Life Membership from the American Occupational Therapy Foundation.

Med, nursing students receive fellowships

Medical student F. Brian Brautigan, formerly of McMechen, was one of approximately 15 students nationwide to receive a medical student pathology fellowship from the American Society of Clinical Pathologists. Brautigan took his one-month fellowship with Dr. John P. Sheils at Cabell Huntington Hospital.

Laura Farnsworth of Parkersburg, a junior in MU's School of Nursing, has been awarded a prestigious Fuld Fellowship. She was one of 53 nursing students selected from more than 400 nominations for the fellowship from throughout the U.S.

The fellowship allows her to attend a special program in Edinburgh, Scotland, and London, England.

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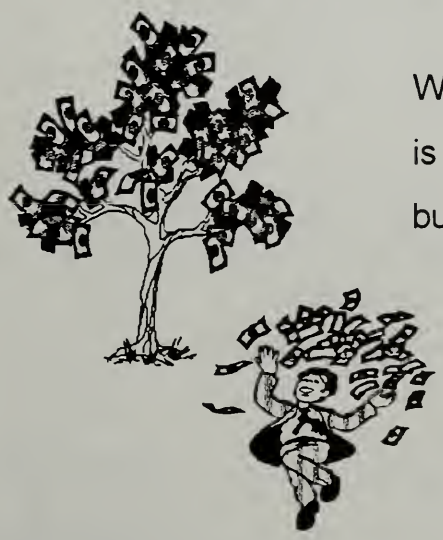

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West Virginia Society of CPAs

The West Virginia Society of CPAs

Alliance News

Early planning is the key to success

CONGRATULATIONS AND BEST WISHES to those of you assuming office this spring!!

I'd like to make a suggestion to the new officers who are currently planning their future programs -- INVITE THE WVSMA ALLIANCE PRESIDENT TO VISIT YOUR COMPONENT ALLIANCE -- preferably early in the year! I can't tell you how much I have enjoyed the visits with the various counties this year (I still have three scheduled). After visiting across the state with other organizations, nothing can beat the hospitality shown by the Alliances I've had the pleasure of meeting with. Thanks for all the courtesies you've extended to me this year. It really helps when the WVSMAA president can visit EARLY in the year and have a chance to explain the goals and programs for the year -- so often, the local membership isn't aware of what's happening at the state level and how it impacts on them. Not that we aren't glad to come at any time, but early is best. In fact, most of us would be glad to come back again if you really want us to assist or attend a certain event. You don't have to have a SPECIAL meeting to invite us -- just a time when your membership is available and we can have a few minutes to talk your group.

Another subject I feel it is important to discuss at this time is the WVSMA Alliance Convention, which is coming up August 18 and 19. I hope you will make every effort to attend!! We've consolidated the convention into just 2 days in an effort to help those who are concerned about missing too much time at work, being away from home too long, or spending too many nights at The Greenbrier! You can attend the whole convention and only spend 1 night away from home.

The Preconvention Board meeting will be conducted Friday morning, the First Session of the House of Delegates will be Friday afternoon, the Second Session of the House of Delegates is set for Saturday morning, and the Post Convention Board meeting is scheduled for Saturday afternoon -- just 2 days, 1 night! I know many of you go to The Greenbrier with your spouse anyway, so why don't you come to our meeting (we'll have reserved seating for those who aren't delegates). You will learn a lot about what YOUR Alliance is doing for your spouse's profession and your community. Registration will take place in the Lower Lobby of The Greenbrier on Thursday afternoon, and outside our meeting room (the Fillmore Room).

This year's convention will be the 70th anniversary celebration for the WVSMAA and we have some special events planned, including two that need your help. On Friday, I will host the President's Luncheon for my board and other dignitaries. In keeping with our anniversary theme, we are having a style show of fashions from the last 70 years during the luncheon -- clothing that might have been worn for any of the various activities at WVSMAA Conventions during the years. We need clothing from the 20s through the current time, as well as models. If you have access to clothing from these time periods and would be willing to model it, or loan it to us to have it modeled, please contact WVSMAA Convention Chairs Jeannie Kalagioclu or Denny Fischer, or me. We would like to have all the decades represented.

At the meeting, I would also like to have a display of county Alliance memorabilia that relates to the WVSMAA. Please be prepared to have it marked for ownership, as well as have someone arrange it in the designated space and remove it after the convention. In addition, let's try to get former WVSMAA officers and members to attend this convention. We will be especially honoring those who have been members for at least half of our Alliance's "life" (35 years or more), as well as former state presidents.

We're trying to make this a really SPECIAL convention for everyone;.YOUR ATTENDANCE will make it really special for ME!!

Sue Bryant
WVSMAA President

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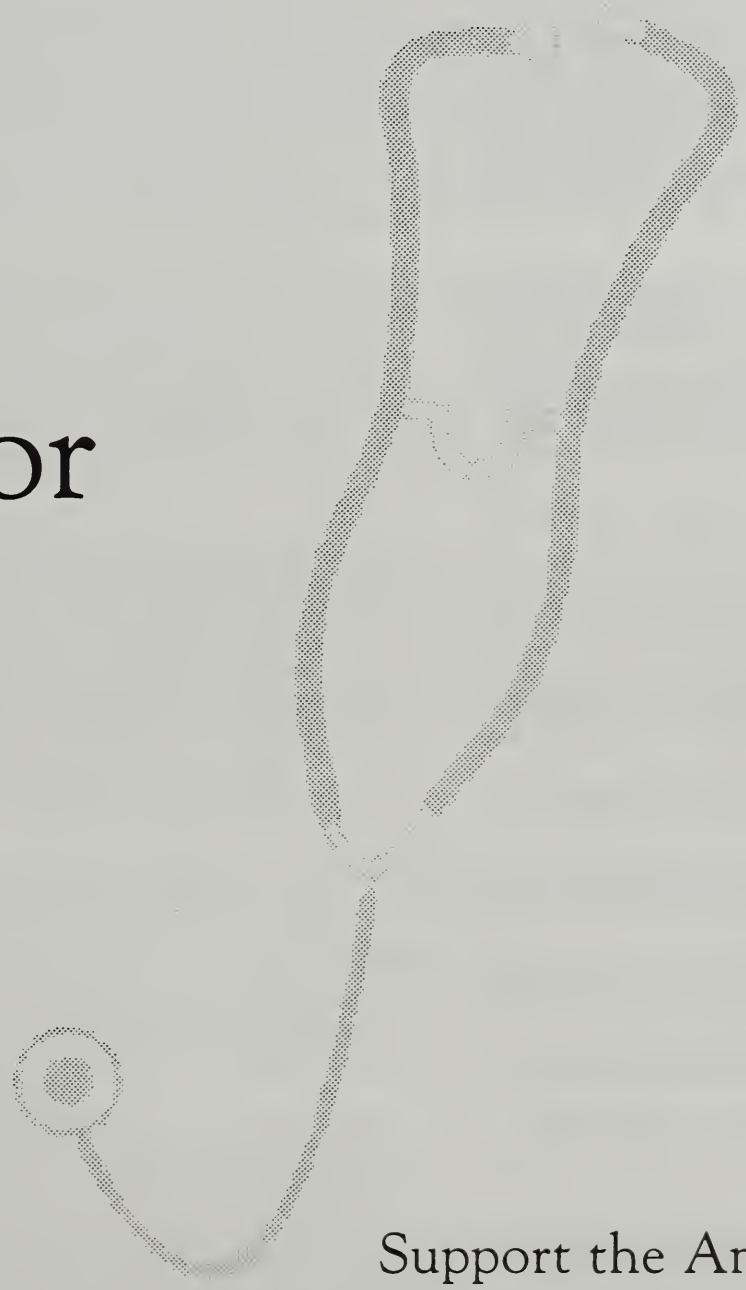

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Med Student Section

Serious business

While many people were out playing tricks on April Fools Day, the new WVSMA-MSS officers got down to business and conducted our first Council Meeting of the year. This very productive meeting was attended by myself, as well as MSS officers Melissa Matulis, vice president; Kristin DeHaven, secretary/treasurer; Linda Burstynowicz, WVU Morgantown counselor; and Bonnie Bailey, WVU Charleston Division counselor. It was also rewarding to have input at this meeting from Abigail Winters of the West Virginia School of Osteopathic Medicine; Dave Faber, MSS immediate past president; and Donna Webb, WVSMA membership coordinator.

This event was my first opportunity as president to officially discuss my goals for the year. First and foremost, I believe it is critical that we increase the membership of the MSS. Currently, only half of all the medical students in West Virginia are members, and I hope to see this total increase to 75%. My next goals are to have MSS members elected to AMA committees, and to increase the involvement of the MSS members who belong to the chapter at the West Virginia School of Osteopathic Medicine. My final goal for the year is to form a committee devoted to the subject of tort reform in order to explore what actions MSS members can take to push this issue.

Following my address, MSS Vice President Melissa Matulis spoke to those in attendance about her priorites for the year - - to delineate the role and function of the vice president; and to create a publicity campaign not only to increase membership, but to also educate medical students about the role and function of the MSS. In addition, MSS Secretary/Treasurer Kristin DeHaven then described her goal of increasing the MSS's involvement with the community via community service projects. To this end, Kristin will be serving as chairperson of the new Public Relations Committee formed by the MSS.

During the remainder of the meeting, a number of other issues were addressed including:

1. **The Membership Committee** - This committee will be chaired by the president of the MSS Executive Council, and the vice presidents of the component societies will be members.
2. **MSS Annual Meeting Committee** - This committee will be chaired by the vice president of the MSS Executive Council, and the presidents of the component chapters will be members. It was recommended that speakers be obtained as soon as possible for this year's MSS Meeting which will take place in January in Charleston during the WVSMA's Mid-Winter Clinical Conference.
3. **Finance Committee** - This committee will be chaired by the MSS secretary/treasurer of the Executive Council, and the secretary/treasurers of the component chapters will be the members.

In conclusion, I would just like to remind everyone that the AMA Medical Student Section will be holding its Annual Meeting in Chicago on June 15-18. Melissa Matulis and I will be attending as delegates from WVU, along with delegates Mary Jo Martin and Mary Rose Boehm of Marshall University. If anyone else is interested in attending, financial assistance may be available to help defray the cost of the trip. Interested MSS members should contact either myself or Donna Webb as soon as possible.

If you have questions about the MSS, please contact me or Donna Webb at 925-0342 or 1-800-257-4747.

Dominic Cottrell, MSIII
WVSMA-MSS President

New Members

We would like to welcome the following physicians to the WVSMA:

Sarah McCarty, MD
Huntington, WV

Mark Studeny, MD
Huntington, WV

Silvestre Cansino, MD
Huntington, WV

Thomas C. Rushton, MD
Huntington, WV

Ralph Webb, MD
Huntington, WV

Ernest R. Breitinger, MD
Ravenswood, WV

David Shamblin, MD
Beckley, WV

Alan W. Cashell, MD
Elkins, WV

Bahram Chubineh, MD
Summersville, WV

Krishnajivan C. Shah, MD
Summersville, WV

Judith M. Knoll, DO
Wheeling, WV

Clark D. Adkins, MD
Charleston, WV

Manolo D. Tampoya, MD
Williamson, WV

Michael P. Giannamore, MD
Follansbee, WV

David Surdyka, MD
Pt. Pleasant, WV

Mary Anne Villegas, MD
Pt. Pleasant, WV

Hyla Harvey, MD
Huntington, WV

Ray Greco, MD
Weirton, WV

Stevan J. Milhoan, MD
Parkersburg, WV

Robert B. Miller, MD
Bluefield, WV

Russell I. Voltin, MD
Charleston, WV

Component Society News

FAYETTE

Mrs. Joe Jarrett, president of the Fayette County Medical Alliance, and Alliance members Bahram Khorshad, Amor Maducdoc and Lolita Amjad, presented members with red carnations in honor of Doctor's Day. Mrs. Jarrett expressed the appreciation of the Alliance members for the continued high standards of care and professional integrity exemplified by the members of the Fayette County Medical Society.

Gastroenterologist Dr. Wallace Johnson, from Beckley, was the featured speaker for this meeting. He presented a paper on esophageal reflux and also gave a detailed history of Doctor's Day.

Dr. Gosien introduced Purificacion Salgado, M.D., of Montgomery, who submitted his application for membership. His application was forwarded to the Ethics Committee for appropriate action.

In other new business, Dr. Sam Davis gave a report of the activities of the WVSMA Council and announced he would not be able to continue in the position of councilor after his present term expires in August.

At the society's May meeting Dr. Bruce Peterson lectured on "Health Care Reform in West Virginia."

Dr. Salgado's application for membership was approved, and Dr. Davis, who is serving as councilor, reminded members that a successor for his post would need to be elected prior to the WVSMA's Annual Meeting in August. Plans were also finalized for the society's next meeting, which will be a family picnic at Hawks Nest Country Club on June 4 at 2 p.m.

MERCER

At society's April 17 meeting, neurologist Dr. David Grouse discussed "Treatment of the Difficult Headache Patient," A short business meeting was also conducted.

On May 15, members held their next meeting which featured a CME lecture by Dr. Nancy Ann Dawson of Walter Reed Army Medical Center on "Treatment of Advanced Prostate Cancer." This program funded by an educational grant from Zeneca.

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West Virginia Medical
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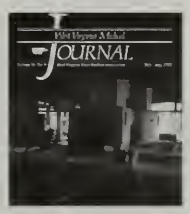

Front Cover

Kate's Mountain Lodge at The Greenbrier will be the setting for a special evening of entertainment with Cajun musician Waylon Thibodeaux at this year's WVSMA Annual Meeting. (See page 218) Photo by of *Shirleen Lipscomb,* executive secretary for the WVSMA.

WVSMA staff members highlighted

George Rider

Executive Director

George functions as general manager of the WVSMA and oversees all staff functions; prepares and recommends the annual budget with the aid of the finance manager and oversees its implementation; recommends programs to the Executive Committee and Council; coordinates legislative activities; works with outside legal counsel; interacts with the Board of Medicine and the various publics; and supervises building maintenance and operations.

Nancie Albright

Associate Executive Director

Nancie assumes the responsibilities of the executive director in his absence; assists the Executive Committee and Council in carrying out the policies in the Constitution and Bylaws; coordinates the WVSMA's Continuing Medical Education Accreditation Program, the Annual Meeting, the Mid-Winter Clinical Conference, and Speakers' Bureau; serves as the WVSMA liaison for Nationwide Insurance Company-Medicare Operations; develops non-dues revenue programs; administers travel policies for educational meetings; and directs two worldwide travel programs for members.

Michelle Ellison

Public Relations/ Advertising Manager

Michelle coordinates all public relations functions for the WVSMA; writes news releases; designs brochures, programs, and promotional materials; works with the finance manager to maintain all advertising accounts for the *West Virginia Medical Journal;* recruits new advertising for the *Journal;* interacts with the managing editor to determine ad placement; proofreads ad copy; serves on the Publication Committee; updates the *Journal's* subscriber mailing; acts as a liaison with county societies in developing mini-internship programs; and represents the WVSMA on the Coalition for a Tobacco-Free West Virginia.

Tim Allman

Director of Operations

Tim manages all office operations and personnel functions, which include development and implementation of policy and procedures relating to employment within the WVSMA; assists the associate executive director in the planning and administration of non-dues revenue programs; provides clerical support for the Annual Meeting, Mid-Winter Clinical Conference; and other workshops sponsored by the WVSMA; and assists with special projects as assigned by the executive director and the associate executive director.

Nancy Hill

Managing Editor/ WV Medical Journal

Nancy writes news articles, edits and proofreads all copy, designs the layout of the pages, and takes photographs for the *West Virginia Medical Journal,* the WVSMA's bimonthly magazine; works with the editor, public relations/advertising manager and printer on various production aspects of the *Journal* and other WVSMA printed materials; assists staff members with proofreading news releases, correspondence, advertisements, brochures, programs and other items; serves on the Publication Committee; and prepares financial statements regarding the *Journal* if needed.

Misty Ramsey

Receptionist

Misty answers and directs incoming calls; coordinates registration for the Annual Meeting and the Mid-Winter Clinical Conference; orders and keeps inventory of office supplies; maintains office equipment and the WVSMA's computer system; types correspondence for the *West Virginia Medical Journal;* opens and distributes mail; assists with special projects; and compiles weekly computer backups of all office files.

Shirleen Lipscomb

Executive Secretary

Shirleen functions as general assistant to the executive director, associate executive director, Executive Committee and Council; performs clerical duties; handles routine information and inquiries related to the daily operation of the WVSMA; coordinates the CME accreditation for hospitals and organizations throughout the state for Category 1 CME credit; schedules visits of the WVSMA president and WVSMA staff members to the component societies; and assists in the planning and registration at the Annual Meeting, the Mid-Winter Clinical Conference and other workshops sponsored by the WVSMA.

Sue Shanklin

Finance Manager

Sue manages all WVSMA finances including the recording of all assets, liability, fund balance, accounts receivable, accounts payable, and investments as needed; maintains biweekly payroll records; prepares monthly general ledger and quarterly tax returns balance sheet, and profit and loss statement; assists and supplies financial data to the auditing firm for preparing annual audit and annual tax returns; prepares annual operating budget and financial statements for the treasurer, Executive Committee and Council; and serves on the Finance Committee.

Winnie Morano

Director of Government Relations

Winnie manages government relations by researching and analyzing legislative issues, lobbying the Legislature, monitoring interim committee meetings, and assisting with the WVSMA Legislative Committee; serves as liaison to the Council; writes and edits *WESGRAM,* WVSMA's monthly publication; and *Legislative Update,* a weekly newsletter produced while the Legislature is in session, and *MedLink,* the WVSMA Alliance's newsletter; and serves as executive secretary to the WVSMA Alliance and to WESPAC, the WVSMA's Political Action Committee.

Donna Webb

Membership Coordinator

Donna coordinates membership dues collection for the AMA, WVSMA and county societies; updates and maintains a data base for members and non-members; plans and implements recruitment strategies for non-members; assists the WVSMA's Medical Student Section and Young Physician Section with all activities; acts as WVSMA's liaison with AMA for membership activities; interacts with county society officers on membership matters; responds to all data requests from staff members and outside organizations; serves as the exhibit manager for the Annual Meeting and Mid-Winter Clinical Conference; and assists with special projects.

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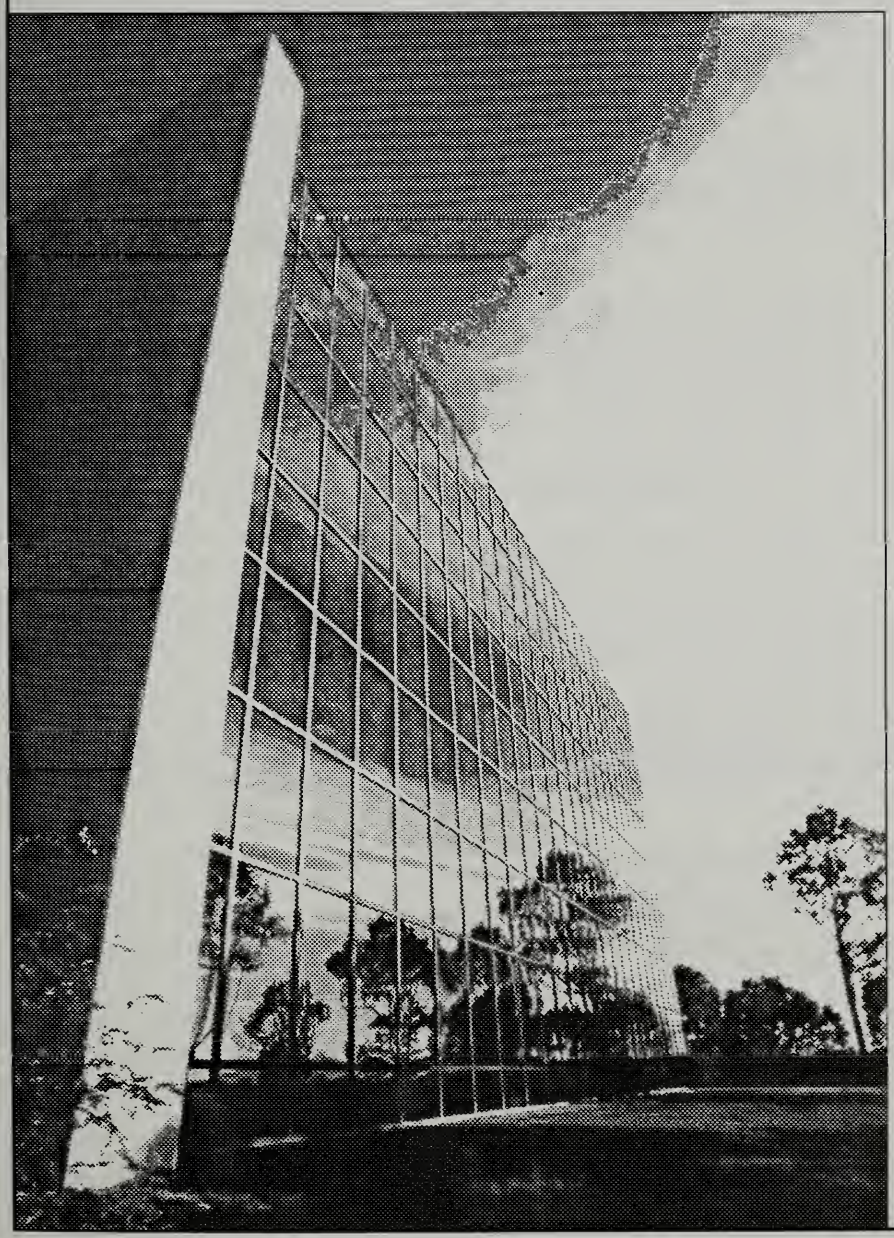

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An overview of the AMA Annual Meeting

The Annual Meeting of the AMA was conducted in Chicago from June 11-15. This year, a major emphasis was the restructuring of Medicare. Unlike two years ago, the AMA has been asked to be involved.

Speaker of the House Newt Gingrich presented his outlook concerning this issue to those in attendance via satellite. He stated, "Health is not just a problem, health is also an opportunity...We have actively reached out to ask the AMA to be at the table..."

Gingrich made a big point in telling us that they are not cutting Medicare or Medicaid. He said the plan actually raises the per person amount to $6,400 from $4,800 over the next seven years. To control the rate of growth, though, there will have to be better ways of delivering health care. The speaker believes in a number of different options, including a Medical Savings Account option, a direct fee for service option, a managed care option, as well as others.

The AMA has adopted a plan that would change Medicare from an open-ended entitlement to a fixed federal contribution per beneficiary, operating on a voucher system. This should open up a fee for service option and free us from Medicare price controls. This plan is not new to the AMA because it was first proposed in 1986. If all this is accomplished, the rate of Medicare's growth would be one-half its current rate.

Dr. Daniel Johnson Jr. of Louisiana was elected president-elect of the AMA after serving as AMA's speaker of the house for four years. He personally vowed to continue to fight for anti-trust relief, so that Medicare reform could be accomplished and we would all have a level playing field in which to negotiate.

The AMA's new president is Dr. Lonnie Bristow. He reminded all of us that "American" in the AMA's title tells us that we are unique to the world, we are not divided into different social classes, and the state is not more important than the individual. "Medical" defines all of the members, their experiences, their responsibilities, and their ethics. "Association," Dr. Bristow stated, tells us that without it, we could only make a difference one person at a time, but with it comes the advantages, the leverage, and the ability to change groups of people and our society.

Several of the other issues that were discussed at the meeting included the possible closing of Los Angeles County Hospital and the effect this would have on millions of people; HMOs in Michigan demanding hospital bylaw changes and getting away with it; tobacco control, gun control, and physician-assisted executions being mandated by states. I feel that all of these subjects are priorities within the AMA which deserve our support and our voice.

On a personal note, I would like to thank Dr. John Markey for his leadership and help over the last 10 years as our current chief delegate. Due to our term limits, he is unable to run again, and we will surely miss him.

David W. Avery, M.D.
AMA Delegate

Special Correspondence

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What percentage of claims are Medicare?
_____0-10% _____10-30% _____30-60% _____More than 60%

If you are processing claims manually:

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Do you fill in claims manually? _____Yes _____No
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Are you satisfied with this service? _____Yes _____No

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JOHN F. WHITE III, M.D.
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Abstract

Carotid duplex ultrasound has been shown to give a more thorough picture of carotid plaque morphology than a carotid arteriogram. As a result, the question has arisen regarding what should be done for the patient who presents with classical hemispheric transient ischemic attacks (TIA) with ulcerative carotid plaque as documented by carotid duplex ultrasound, but with minimal disease on arteriography. This article presents a case illustration of this problem.

Introduction

In the past decade, the use of carotid duplex ultrasound has become increasingly popular in evaluating patients with carotid stenosis (1-4). It has also been shown to give a more satisfactory picture of plaque morphology than the "gold standard" arteriogram (1-5). Therefore, the question arises as to what should be done for the patient who presents with classical, hemispheric TIA symptoms with irregular heterogeneous carotid plaque by duplex ultrasound and with a relatively normal arteriogram?

To help research the answer to this question, we studied the cases of several similar patients who were treated with a carotid endarterectomy (CEA) at the Charleston Area Medical Center in the last several years. This article highlights one of the cases we reviewed.

Figure 1a. Color carotid duplex ultrasound of carotid bifurcation showing irregular heterogeneous plaque of proximal left internal carotid artery, as outlined.

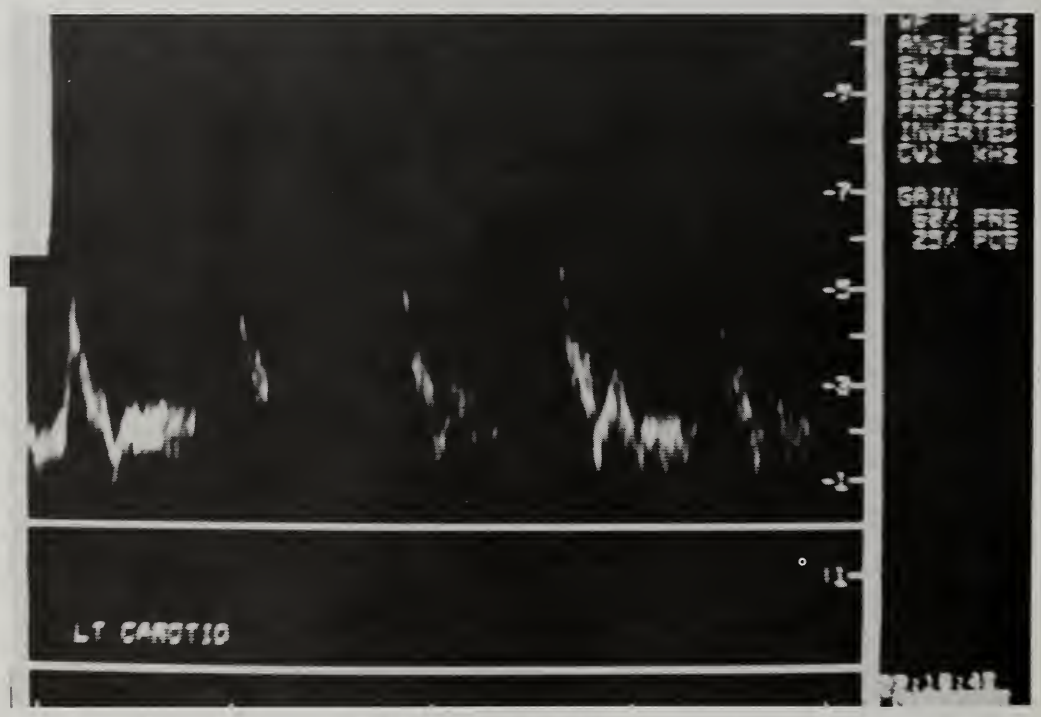

Figure 1b. Carotid spectrum analysis showing a peak systolic frequency of 5 kHz, which is consistent with at least 50%-60% stenosis.

Figure 2. Carotid arteriogram showing minimal disease of < 25%.

Figure 3. Operative specimen of carotid plaque. Please note that plaque is irregular, ulcerative, and heterogeneous.

Case report

A 71-year-old white man was referred to the Vascular Surgery Service at the Charleston Area Medical Center for evaluation of possible carotid artery disease. This patient described a three-month history of occasional numbness in the right arm that would subside within 30 seconds to two minutes. In addition, he had experienced a recent episode of right hemiparesis and paresthesia for which he was hospitalized.

This patient's symptoms were noted to abate within 24 hours and he did not complain about any other problems. These attacks were noted despite antiplatelet therapy. His past medical history was significant for hypercholesterolemia and coronary artery disease, but there were no signs of carotid bruits, diminution of carotid pulses, cardiac disease or neurological deficits.

A carotid color duplex ultrasound revealed moderately significant stenosis of the left carotid bifurcation and internal carotid artery (about a 60% diameter reduction) with a peak systolic frequency of the left proximal internal carotid artery of 5 kHz (Figures 1a and 1b). A preoperative arch aortogram and carotid arteriogram showed minimal plaquing (< 25% diameter reduction) of the left internal carotid artery (Figure 2), and a 30% stenosis of the right internal carotid artery.

A computerized tomography (CT) scan of the brain revealed diffuse cortical atrophy, appropriate for the patient's age, with no other pathology. Neurologic and cardiac work-ups, which included echocardiography and thallium stress testing, were negative for other causes of TIA. A left CEA was planned because of the patient's classic hemispheric TIAs despite antiplatelet therapy and the duplex ultrasound findings.

In surgery, moderately significant stenosis of the left proximal internal carotid artery was found (at least 50%-60%), which was associated with multiple ulcerations with thrombi attached and an area of intraplaque hemorrhage (Figure 3). A CEA was performed with saphenous vein patch angioplasty.

This patient's postoperative course was uneventful, and he was symptom free at one, three, six, and 12-month follow-ups in the clinic. Furthermore, his postoperative color duplex ultrasound examination showed a normally patent internal carotid artery at one and six-month follow-up.

Discussion

This case is representative of a widely debated question in vascular surgery -- What testing is required prior to subjecting a patient to an operation that could result in significant morbidity and mortality?

The basis for carotid endarterectomy developed with a growing knowledge of the natural history of carotid occlusive disease. More recently, the pathogenesis of TIAs, amaurosis fugax, and stroke as a result of embolism from an extracranial cerebrovascular source (carotid artery bifurcation) has been elucidated (1).

In addition, association of cerebral ischemic events with non-stenotic (ulcerative) lesions has received a fair amount of attention (2).

Initially, angiography was the sole test used to "view" the arterial tree; and, as such, it became, and continues to be, the "gold standard" used prior to CEA. However, non-invasive vascular studies have since come on-line and they are being used extensively in screening patients with suspected carotid artery disease. Furthermore, there is a growing body of surgeons who rely solely on carotid duplex ultrasound for preoperative evaluation of their carotid patients (3).

The morphology of carotid plaque is of importance in predicting the natural history of the disease, with primary concern being focused on ulceration and/or whether the plaque is heterogeneous. Duplex ultrasound has been shown to better delineate the shape of arteriosclerotic plaquing and may be used to classify ulceration (4).

With these factors in mind and a case which clearly represents better diagnostic prediction of carotid duplex ultrasound, we propose the following alternatives to the current approach for symptomatic patients with carotid disease:

(1) In patients with classical, hemispheric symptoms and a duplex ultrasound of the carotids revealing hemodynamically significant stenosis, physicians should be allowed to offer operative therapy without feeling pressed to obtain an arteriogram (3-5).

(2) In patients with ulcerative lesions or complicated plaque morphology on duplex ultrasound in whom other etologies for their symptoms have been ruled out, CEA should be performed without further ado, for patients who failed medical treatment (5).

(3) In patients with a symptom complex consistent with carotid disease, such as hemispheric TIAs, stroke or amaurosis fugax, as well as a normal carotid arteriogram, non-invasive studies should be obtained. In addition, if these studies indicate significant disease in the form of either stenosis or ulceration, definitive therapy can then be offered with a degree of confidence.

Conclusions

Carotid duplex ultrasound is superior to carotid arteriography in detecting irregular or ulcerative heterogeneous plaques associated with non-significant stenosis, and it should be used to determine the necessity for carotid endarterectomy in patients with classical TIA symptoms despite a normal arteriogram

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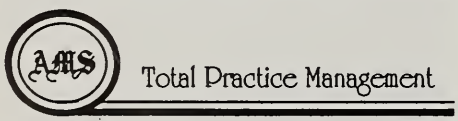

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Guidelines for the use of blood transfusions

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Abstract

Over 11 million units of red blood cells are transfused each year in the United States at a cost of over $2 billion. This paper reviews the indications for and the risks of red blood cell transfusions, and provides guidelines for transfusions in both surgical and non-surgical settings.

Costs and risks of transfusion

Homologous red blood cell transfusion accounts for 11 million units each year in the United States (1) at a total cost of more than $2 billion. This figure does not include the costs of volunteer efforts or the costs of treating such complications as infections and immunological reactions.

Infections

The most common agent transmitted by transfusion is cytomegalovirus (2). The most serious infectious complication of transfusion is hepatitis. The recent development of a screening test to detect anti-HCV (1990) together with the addition of routine testing for Hepatitis B-core antibody and alanine-amino-transferase has reduced the risk of transmitting Hepatitis-C (non-A, non-B Hepatitis) to 1:3,300 (3).

There are also risks associated with transmitting the human immunodeficiency virus (HIV) and the human T-cell lymphotrophic viruses. Recent estimates of risk with HIV transmission vary between 1:100,000 and 1:225,000 per unit transfused, and the risk of human T-cell lymphotrophic transmission is approximately 1:50,000 per unit (3). Transmission of the lymphotrophic viruses by transfusion has been associated with T-cell leukemia, lymphoma, and/or neurological disease several to many years after the transfusion.

There is also still a risk of transmitting cryophilic (cold-loving) bacteria. These organisms have been known to cause endotoxic shock, which can be fatal.

Immunological reactions

Hemolytic and non-hemolytic reactions can result from alloimmunizations by red cells and white cells (2). Hemolytic reactions are virtually eliminated by careful compatibility testing, but when they do occur, they are usually due to human error, resulting from the improper identification of the recipient and donor blood. The frequency of fatal hemolytic transfusion reactions has been estimated to be 1:600,000 transfusions (4). Delayed hemolytic reactions usually occur about seven days after red blood cell transfusions in persons who have been immunized by previous transfusion or pregnancy.

Non-hemolytic febrile reactions occur in 1% - 2% of recipients, usually the result of sensitization by leukocyte antigens (5). Approximately 10% of transfusion recipients develop anti-HLA-A, -B, -C antibodies, and about one person in 600 is deficient in immunoglobulin A (IgA) (5). Those individuals who develop antibodies to the IgA component of donor blood may suffer serious and sometimes fatal anaphylaxis when transfused. These reactions, usually occurring after the start of a transfusion, can be avoided by giving patients known to have this deficiency either washed red blood cells (3) or plasma from a donor deficient in IgA.

The frequency of these severe anaphylactic reactions is very low, but mild allergic reactions manifested by the onset of urticaria are relatively common (3). (Urticaria is not a manifestation of hemolytic transfusion reaction.) Some physicians continue to transfuse after giving an antihistamine drug, such as Benadryl, while others advocate stopping the transfusion. The incidence of allergic reactions of urticaria, fever, and/or chills, is about in 1:100 transfusions (3).

Rationale for transfusion

The rationale for red blood cell transfusion is to increase the oxygen delivery. Volume expansion is not an indication for red blood cell transfusion, nor is there any evidence that blood transfusions reduce the risk of infection, promote wound healing, or enhance well-being.

Tissue oxygenation is well maintained at hemoglobin levels well below 10g/dl. Anemia leads to an increase in the concentration of 2,3-diphosphoglycerate (2,3-DPG) in red cells, which decreases their affinity for oxygen and allows more to be released to the tissues (2). A shift to the right of the oxyhemoglobin dissociation curve enhances oxygen release at constant oxygen levels. A shift begins when the hemoglobin level falls to 9 g/dl and is more prominent at levels below 6.5 g/dl. Following blood loss, a shift takes 12 to 36 hours to develop. A second and more immediate basis for augmented oxygen release is the Bohr effect, in which hemoglobin develops decreased affinity for oxygen in the presence of systemic acidosis (2).

Animals can withstand acute anemia when their total blood volume is maintained, and anesthetized dogs can tolerate hemoglobin levels as low as 2 to 5 g/dl when blood volume is maintained. Patients who refuse transfusion for reasons of religion, tolerate hemoglobin levels well under 10 g/dl. Indeed, otherwise healthy patients with normal intravascular fluid volumes maintain their cardiac outputs until the anemia is profound (2).

Current practice

Decisions to tranfuse blood should be based on the need to increase the oxygen-carrying capacity of the circulating blood. The oxygen-carrying capacity reflects many factors, including the patient's age, the severity and acuteness of blood loss, the severity and variety of anemia, and the presence or absence of cardiovascular, pulmonary and renal diseases.

Historically the "10/30 rule" (hemoglobin under 10 g/dl or hematocrit under 30%) was used as a guideline for determining the need of blood transfusion among surgical patients, based on the belief that lower values were associated with impaired tissue oxygenation. Recent surveys have revealed variations in transfusion practice among anesthesiologists. Table 1 shows variations in the incidence of transfusions retrospectively judged to have been unnecessary (2).

Alternatives to homologous transfusion

Autologous donations are those in which the patient donates well in advance of a surgical procedure and subsequently receives his or her own blood components. This type of donation eliminates both the risk of transmission of viruses from homologous blood and immunological reactions.

The use of autologous red blood cells has increased greatly over the past decade. In addition, blood salvaged during surgery and then transfused is now an option in some surgical settings, although current technology to perform this procedure is expensive. Research continues into the use of erythropoietin to increase the number of autologous blood donations by an individual and to decrease the need for transfusion in the anemia of chronic renal disease.

Clinical guidelines have been developed for the appropriate use and timing of red blood cell transfusion. The principles and guidelines which begin below are a synthesis of those published by the American College of Physicians (6) and the report of the Consensus Conference of the National Institutes of Health (5).

Principles of management

General Principles:

Rule 1: Determine whether the patient is anemic due to acute factors (blood loss) or chronic factors (vitamin or iron deficiency). The approach to these two types of anemia can differ.

Rule 2: Consider what symptoms require alleviation and what, if any, alternative treatments are available such as replacement with iron, vitamin B-12 or folate, or stimulation by erythropoietin.

Rule 3: Discuss autologous transfusions before elective surgery.

Rule 4: If possible, discuss the benefits and risks of transfusions with the patient to reach a mutually acceptable decision, and record the discussion.

Guidelines

1. Avoid use of an empirical transfusion "trigger" threshold, such as a hemoglobin level under 10 g/dl.
2. Regard elective transfusions with homologous blood as an avoidable outcome.
3. Try to plan for the availability of autologous blood when acute blood loss can be predicted (before elective surgery).
4. Transfuse unit-by-unit; one unit may be sufficient.
5. Consider erythropoietin to treat anemias associated with chronic diseases, such as AIDS, chronic renal failure, AZT therapy, cancer, and cancer treated by chemotherapy.
6. Transfusions should be considered in these conditions:
   A. Acute anemia: to relieve symptoms related to acute blood loss when crystalloid solutions alone have failed to correct intravascular volume depletion.
   B. Chronic anemia: to relieve symptoms related to decreased red blood cell volume when other interventions, such as vitamin and iron replacement and erythropoietin, have failed.
7. Transfusion should not be used for the following reasons:
   A. To enhance general well-being;
   B. To promote wound healing;
   C. To expand intravascular volume when crystalloids will suffice; and
   D. Prophylactically in the absence of symptoms.

Table 1. Unnecessary Use of Red Blood Cell Transfusion.

Study	Year	Patients	Site	Criteria for Transfusion	Proportion of Transfusions Judged Unnecessary
Diethrich	1965	217	General Hospital	Preoperative Hgb < 10.0 g/dl; blood loss > 500 ml; symptomatic anemia + Hgb < 7.0 g/dl	26% of multiple-unit transfusions, 68% of single-unit transfusions
Reece Beckett	1966	855	Teaching Hospital	Hgb < 12.0 g/dl (women) Hgb > 13.6 g/dl (men)	67% of all single-unit transfusions
Friedman	1978	3,616	300 Hospitals	Hgb < 10.0 g/dl	13% of patients receiving transfusions
Moses, et al	1989	560	Teaching Hospital	Preoperative Hgb < 7.5 g/dl; Hgb < 7.5 g/dl + history of a cardiac disorder, symptomatic anemia + Hgb < 10.0 g/dl	51% of all transfusions
Coffin, et al	1989	245	Teaching Hospital	"Criteria map" algorithm	4% of patients receiving transfusions
Goodnough, et al	1991	386	18 Teaching Hospitals	Discharge Hgb > 11.0 g/dl Received 1 or 2 units after the day of surgery	41% of patients receiving transfusions 13% of patients receiving transfusions

Transfusion for Transient Anemia from Acute Blood Loss

These situations include trauma, elective surgery and obstetrical delivery.

1. Asymptomatic patients
   A. It is important to assess overall intravascular volume and, if depleted, restore with crystalloids. Normovolemic anemia with a hemoglobin of 7 to 10 g/dl is well tolerated in most patients.
   B. In an asymptomatic normovolemic patient with risk factors (Table 2), transfusion is not indicated unless the patient develops symptoms or unstable signs (Table 3). In a patient without risk factors, transfusion is not indicated independent of the hemoglobin level.
2. Symptomatic patients
   A. Use crystalloids to replace intravascular volume.
   B. If symptoms persist, transfuse autologous blood first, if available, or homologous blood on a unit-by-unit basis, to relieve symptoms and signs. Remember, one unit may be sufficient.

Table 2. Patients at Risk for Myocardial Ischemia, Cerebral Ischemia

Risk factors for myocardial ischemia
- Coronary artery disease
- Valvular heart disease (e.g., severe aortic stenosis)
- Congestive heart failure

Risk factors for cerebral ischemia
- History of transient ischemic attacks
- Previous thrombotic stroke

Table 3. Symptoms and Signs of Patients with Depleted Intravascular Volume and/or Red Cell Depletion

Syncope	Angina
Dyspnea	Postural hypotension
Tachycardia	Transient ischemic attack

Table 4. Autologous Transfusion Strategy

Preoperative autologous donation	Intraoperative blood salvage
Preoperative hemodilution	Postoperative blood salvage

Table 5. Erythropoietin Therapy

Uses
- In anemia related to AZT treatment for AIDS
- In anemia of chronic renal insufficiency (creatinine > 1.8 mg/dl)

Advantages
- Reduction in blood-transfusion requirements in AZT-induced anemia
- Reduction in blood-transfusion requirements in chronic renal insufficiency
- Functional improvement of patients with chronic renal insufficiency

Disadvantages
- Increased risk of hypertension in patients undergoing hemodialysis
- Increased incidence of thrombosis of vascular access in patients undergoing hemodialysis
- Expense

3. Patients under anesthesia with stable vital signs
   A. Assess the patient's risk for cardiac or cerebral ischemia.
   B. In the absence of risks, transfusions are not indicated independent of the hemoglobin level.
   C. Intravascular volume should be restored with crystalloids.
4. Patients under anesthesia with unstable vital signs
   A. Assess the patient's risk for cardiac or cerebral ischemia.
   B. Patients at risk should receive blood transfusions on a unit-by-unit basis; use autologous blood first, and evaluate the patient after each unit.
   C. In the absence of apparent risks, intravascular volume should first be adequately restored with crystalloid solutions.

Pre-operative management (Table 4): If blood transfusion is anticipated, consider autologous blood donation pre-operatively, or intra-operative or post-operative blood salvage.

Transfusion for Persistent Anemia

Weigh the immediate benefits of transfusion against the long-term risks in the context of the natural history of the disease and the survival of the patient. Target patients include those with anemia due to cancer and cancer therapy, AIDS, chronic inflammatory diseases, and renal insufficiency.

Asymptomatic Patients

1. Rule out reversible anemia such as B-12, folate and iron deficiency. These anemias can be treated with repletion of these elements. Consider the use of erythropoietin in the anemias responsive to it (Table 5).
2. Transfusions are not indicated in the absence of risk factors in asymptomatic patients.

Symptomatic Patients

Transfuse packed red cells to relieve symptoms and provide a red blood cell volume that will maintain the balance between adequate tissue oxygen delivery and a level of activity consistent with an acceptable quality of life and maximal survival from underlying disease.

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Coronary artery muscle bridging causing Class III angina in a patient with no coronary atherosclerosis

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Abstract

The significance of coronary artery muscle bridging (MB) has been debated since its first angiographic description by Portsmann and colleagues in 1960 (1). The course is usually benign; however, angina, myocardial infaction, sudden death, arrthythmias, and complete heart block have been reported. In this article, we present a case of coronary artery muscle bridging which caused a patient with no angiographic evidence of atherosclerosis to experience Class III angina.

Case report

A 43-year-old white female was admitted to the Charleston Area Medical Center for the evaluation of midsternal chest pain, which had been radiating to both arms with minimal exertion (Canadian Cardiovascular Society Class III). She had been able to obtain relief from her symptoms by taking sublingual nitroglycerin and resting.

Previously, this patient had been evaluated twice for less limiting angina by cardiac catherization, at ages 22 and 37, but she reported having exertional angina "as long as I can remember." Neither of these angiographic studies had indicated atherosclerotic disease; however, the second study did show a 50% narrowing of a 25 mm long segment in the left anterior descending coronary artery during systole. Mitral valve prolapse was also seen when the second study was conducted, and she was found to have mild pulmonary valvular stenosis with a mean pulmonary valve gradient of 12 mmHg.

From the time of her second study until she was admitted to CAMC, this patient continued to experience worsening angina despite treatment with several classes of anti-anginal drugs including nitrates, calcium antagonists and beta blockers. Her past history was unremarkable for previous myocardial infarction, hypertension, diabetes mellitus, rheumatic fever or smoking.

When she arrived at CAMC, her cardiovascular examination revealed a Grade II/VI mid systolic murmur greatest at the upper sternal border. Vital signs were normal, and the chest X-ray revealed a normal heart size. Other routine studies were normal.

An ECG showed sinus rhythm with right axis deviation, poor R-wave progression in the precordial leads and non-diagnostic Q waves in the inferior leads. A maximal bicycle exercise stress test was negative to a peak heart rate of 178/min. and thallium images were unremarkable.

Utilizing percutaneous femoral technique, a right and left heart catherization was conducted which indicated mild mitral valve prolapse that had not changed since her second previous catherization at age 37. The left main, right and circumflex coronary arteries were entirely normal and showed no evidence of atherosclerosis.

Left ventricular angiography showed an ejection fraction greater than 60%. The cardiac index was normal, and there was no evidence for idiopathic hypertrophic subaortic stenosis. The left anterior descending (LAD) artery revealed a 25 mm long segment with greater than 80% narrowing only during systole (measured with hand-held calipers in two orthogonal projections). Ergonovine maleate was given in 0.1 mg and 0.2 mg doses 10 minutes apart, and this vessel was viewed again 8 minutes after the last dose. No systolic narrowing was seen, and there was no evidence of atherosclerotic disease in the LAD.

A periarterial muscle resection was performed in the area of the muscle bridge under general anesthesia and cardioplegia. A two-inch segment of muscle overlying the mid-left anterior descending was divided.

Postoperatively, this patient did well, with no evidence of perioperative myocardial infarction. She has remained asymptomatic for the past five years and not complained of chest pain with moderate to heavy exertion. She is currently able to perform activities such as climbing hills and playing 18 holes of golf, that she could never do before without pain.

Discussion

A myocardial bridge (MB) occurs when an epicardial coronary artery becomes encircled by myocardial fibers for a limited segment and then returns to the epicardium. In clinical practice, the term myocardial bridge is used to described an angiographic occurence -- systolic narrowing of a coronary artery.

Myocardial bridges are found in 5%-86% of hearts examined at autopsy (2,3,4), and in 0.5%-12% of patients undergoing coronary angiography (5). The most frequent site of MB is the middle segment of the left anterior descending artery (6). It has been associated with angina (7), myocardial infarction (8,9), arrhythmias (10), complete heart block (10), and sudden death (11).

The angiographic evaluation of systolic narrowing in patients with MB is difficult since the geometry of the vessel is altered. In diastole, the cross-sectional area of the vessel is circular and assumed to be normal. During systole, the cross-sectional area may take on an elliptical shape that can cause an overestimate of the systolic narrowing if only one view is used; therefore, an adequate estimate of the degree of narrowing should be based on at least two orthogonal projections.

The lack of atherosclerosis in this patient is not unusual. It has been postulated that MB may have a protective effect against atherosclerosis at the level of the muscle bridge. There is controversy, however, as to whether it may promote fixed lesions proximal to the MB by increasing the turbulence in that area. In one study, the frequency of proximal fixed lesions of the left anterior descending artery were found with similiar frequency in patients with and without MB (60% and 50% respectively).

Non-invasive testing has not been particularly helpful in detecting ischemia due to muscle bridging in symptomatic patients. The most frequently reported ECG changes are T-wave changes at rest (suggestive of ischemia or hypertrophic cardiomyopathy). These T-wave changes may be persistent or intermittent. In one study, T-wave changes at rest were observed in 10/45 (23%) of patients with myocardial bridges not associated with any fixed lesions (12).

The literature has been conflicting as to whether thallium imaging is useful in detecting ischemia associated with muscle bridging. A recent study by Bennett and colleagues suggests that thallium imaging with dipyridamole may induce redistribution abnormalities (13). One possible explanation for negative exercise testing with MB may be that the rise in blood pressure with strenuous exercise testing counteracts the contractile strength of the MB so that systolic compression is attenuated.

Another investigational tool that has received attention is metabolic testing. Noble and colleagues found ischemia as evidenced by lactate extraction during atrial pacing at 150 bpm in 4 of 11 patients with myocardial bridges (7). Three of the four patients had a history of typical angina with EKG findings of ischemia during atrial pacing; however, three other patients also had a history of typical angina with angina and ST-T wave changes during atrial pacing, but demonstrated no lactate production. A study by Loures and his colleagues was similarly inconclusive (14).

Since conventional non-invasive testing for myocardial ischemia due to MB has been inconsistent, provocative testing has been performed. Angelini and colleagues (12) carried out provocative testing, and of the 50 patients with isolated MB who received nitroglycerin, none developed chest pain or ST segment changes (Table 1). However, patients who received intravenous vasopressors experienced chest heaviness which was unrelated to the degree of systolic narrowing. In our patient, ergonovine was administered with resolution of the systolic narrowing, which is consistent with the findings of Angelini et al (12). Since ergonovine raises systolic and diastolic blood pressure, this may have counterbalanced the contractile effect of the muscle bridge.

A recent case report by Ciampricotti and colleagues implicates vasospasm as a possible cause of angina in patients with myocardial bridges (15). However, changes in systolic blood pressure (afterload) may account for some of the dynamic variability seen with this condition. Changes in local vasomotor tone, nevertheless, might also affect the degree of stenosis at the site of muscle bridging.

Table 1. Muscular Bridges: Factors Influencing The Angiographic Severity of Systolic Narrowing

Factor	Effect
Pacing (150/min)	0 or ↓
Ergonovine (0.4 mg IV)	0 or ↓
Neo-synephrine (0.1 mg IV)	0 or ↓
Isoproterenol (0.05 mg IV)	↑
Epinephrine (0.05 mg IV)	↑
Nitroglycerin	↑

Modified from Angelini et al

The treatment of MB has consisted of drug therapy, MB resection and/or coronary artery bypass grafting. Pharmacologic therapy with beta blockers theoretically might reduce myocardial contractility and prolong diastolic filling. Calcium entry blockers may have a similiar mode of action and also relax coronary artery vascular tone. However, neither class of drug was helpful for our patient. Aspirin is indicated only if an atherosclerotic lesion is present.

The surgical treatment of MB consists of periartierial muscle resection which "unroofs" the overlying MB or coronary artery bypass grafting if the MB is not resectable. Left ventricular aneurysm has been reported as an unusual complication of MB resection (16). The five-year survival rate for patients who undergo MB resection approaches 98% (17).

Conclusion

Coronary artery muscle bridging is not uncommon, but it is frequently asymptomatic. It can, however, produce limiting angina without producing abnormalities by exercise testing.

In the case of the patient we describe in this article, medical therapy with beta blockers and calcium entry blockers alone and in combination were unsuccessful in alleviating her angina. However, surgical intervention alleviated the coronary muscle bridging and completely relieved the patient's angina without a recurrence of symptoms.

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Scientific publications and scientific style

GERALD M. HIGA, PHARM.D.
Assistant Professor of Clinical Pharmacy, School of Pharmacy, Mary Babb Randolph Cancer Center, West Virginia University, Morgantown

Abstract

The publication of scientific information should be the natural outcome of research. However, scientific style demands logic, precision, clarity and brevity - - qualities often setting it apart from literary style. This paper highlights a 10-step approach to preparing a scientific manuscript.

Introduction

Research can be described as a continuum whereby methods are developed, data are collected, analyzed and summarized, and conclusions are stated. It is one of the primary missions of an academy and critical for the reputation of all academicians and institutions.

Since productive and continuous research enriches the collective well-being of a university on a community, state, and sometimes national basis, enormous responsibility is placed on individual faculty members to support research efforts. Still, it is unlikely that researchers attain almost heavenly status with statistically significant data because research without publication condemns one to an academic form of purgatory. Scientific writing, then, is an inevitable part of research since no research is complete until it is published.

Table 1. Guidelines for writing a scientific paper

1. Construct a master plan.
2. Create a title and write an abstract.
3. Design figures and construct tables.
4. Organize the manuscript's outline.
5. Write the first draft.
6. Revise the first draft.
7. Critically assess the revision.
8. Have others review the paper.
9. Polish the paper.
10. Prepare in final form.

Most professional researchers are not professional writers. Despite their command of the English language, scientific writing is most often an arduous, and sometimes even foreign undertaking. Indeed, writing scientific papers is not easy, in large part, because of the complexity of the subject and the strict requirement for a succinct, yet comprehensive and clearly written manuscript.

The writing process

The preparation of a scientific paper parallels that of a scientific study in that logic should precede language. Furthermore, logical planning and precise research methods mutually intersect with rational thinking and concise scientific writing. The fear of preparing a scientific publication should be balanced by the attention it will attract, the verification of the research reported and its possible impact.

The "literary style" of scientific writing is said (and needs) to be characteristically unpretentious, direct and accurate. Even though effective scientific writing does not contain flowery prose, it should not be unimaginative. Scientific papers will be structurally sound if the construction is based on logical thought, accurate details and unambiguous presentation.

The following steps, which are outlined briefly in Table 1, will enable a prospective author to prepare a scientific paper.

Step 1. Construct a master plan

Even before writing a manuscript, it is appropriate to ensure that there is sufficient data or information to answer the questions being asked. The author should begin writing when the research is nearing completion, not when it is finished, and be aware of whether a significant advance in knowledge will be made.

It is also important to consider which journal would be the most appropriate for the material that will be presented.

Step 2. Create a title and write an abstract

Although some individuals have advised against creating a title and abstract this soon in the writing process, I believe it is particularly beneficial because it gives the author an opportunity to clarify his/her goals and objectives.

In addition, the abstract serves to help organize a tightly constructed article that is free from irrelevant material which is often contained in the initial draft.

Step 3. Design figures and construct tables

It is especially critical to design figures and construct tables that are complete and informative, yet easy to read and understand. Any tabulated data should support the study conclusions, and creativity can have an immense impact on the clarity of the information outlined.

Step 4. Organize the manuscript's outline

Now, it is important to determine what information will be discussed in each section of the manuscript. An author should consider building a "reservoir" of information for each section without regard for order of presentation or level of importance. Usually, some of the sorted information will be included in other sections or eliminated entirely.

Step 5. Write the first draft

The initial draft should be written with the objective of unifying the article. Although there is no universally accepted procedure, I suggest writing the first draft by sections, from easiest to most difficult. Subconsciously, this may help an author get over the initial trauma of writing the paper.

The introduction should be concise and address the area of research or interest, present previous findings, as well as state the objectives or nature of the paper. Do not underestimate the purpose of this section since it serves to stimulate reader interest. It is also important to construct a list and have copies of references when preparing the initial draft.

Next, the materials and/or methods section can be undertaken. This part of the manuscript should utilize enough detail to allow others to evaluate the study's methodology and to conduct their own experiments using methods employed in your study.

The results section must emphasize salient features of the study that allow the data to speak for itself, and should not tediously repeat what should be clear from the tables and figures. Don't be sidetracked by including an extensive discussion comparing the results of other studies with your own in this section.

The discussion section is the heart of the paper, and likely, the most difficult section to prepare because authors must assess the meaning of their results. Controversial issues and conflicting study findings must be presented clearly and fairly. Most importantly, differences require explanation rather than refutation. Authors can speculate, but the ideas must be reasonable and firmly founded in astute observation, prudent contemplation, and above all, rigorous investigation.

Step 6. Revise the first draft

After the first draft is completed, even the best writers are prepared to revise their manuscripts, and I suggest two broad approaches.

First, carefully seek out flaws even though much work and preparation went into constructing the manuscript outline. Read every sentence looking for faults of logic. Re-examine cited references and carefully inspect statements about previously published papers. The consequences of misleading or misrepresenting the work of other authors is potentially catastrophic; well-informed readers and journal editors lose confidence in the author's competence while the unacquainted will be misled. Review the order of the information presented, making sure that it flows smoothly and check to see if tables can be combined or simplified.

Second, refine the style. It is clear that "scientific style" and "literary style" do not necessarily overlap. While revising the first draft, keep in mind the major style considerations for scientific papers. In contrast to literary style, scientific style requires rational construction of sentences and paragraphs (logic), exactness of details (precision), reader comprehension (clarity), and brevity of content (directness). Wit, humor and grace of prose, though not necessarily undesirable, are not essential.

Step 7. Critically assess the revision

The first revision is seldom the last. Even before considering having others read the paper, reassess the entire manuscript to make sure it is direct, simple, lucid and precise. I cannot overemphasize that scientific writing must also be efficient, when the only means ensuring idea transfer is avoiding ambiguity.

Step 8. Have others review the paper

It is extremely worthwhile to have your paper reviewed by several other individuals, one of whom should not have a scientific background. While your colleagues can offer advice about study methodology, data presentation and rationality of conclusions, the non-scientific reviewer can be just as valuable by offering comments on grammar, sentence and paragraph structure and coherence of the manuscript.

In addition, these reviewers give authors something they are unable to provide for themselves: distance from the manuscript.

Step 9. Polish the paper

The final stages of manuscript preparation involve putting the final touches on the paper. Graphs, tables and figures should be professionally created. The title and abstract need to be rewritten in final form taking into consideration the fact that these items were initially written by you to clarify your purpose in writing the manuscript. It is now time to think of the title and abstract from the reader's perspective.

The title should be an effective guide for readers, many of whom rapidly scan lists of journals for relevant and important articles. Furthermore, after the title, the abstract is the reader's first contact with the paper, so it must be able to stand alone and be intelligible without reference to the text.

Step 10. Prepare in final form

The final step that must be conducted is to review the journal's instructions or guidelines to the author before typing the manuscript in submission form. I recommend shelving the manuscript for a week; it can then be re-evaluated one final time with a rested eye.

Conclusion

The full power of research can be unleashed through the beauty of a published scientific paper. Scientific style may lack the grace of a literary genius, but it should not lack polish, symmetry, logic, clarity or precision.

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WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE
OFFICE OF CONTINUING MEDICAL EDUCATION

Second Annual Primary Care Perspectives on Women's Health

August 25-27, 1995

Robert C. Byrd Health Sciences Center of West Virginia University
Morgantown, WV

Registration is requested by August 4, 1995.

Name _____ Degree _____
(as it should appear on your nametag and certificate.) (MD, PhD, etc.)

Firm _____ Date of Birth _____/_____/_____

Home Address _____

City_____ State _____ Zip_____ County _____

Work Address _____

City_____ State _____ Zip_____ County _____

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Social Security Number _____ - _____ - _____ FAX Number ( )_____

Specialty_____ Subspecialty _____

Hospital Affiliation(s) _____

Course Fees∆		Before Aug.4	After Aug.4	Total
Full Conference		$150.00	$185.00	$
Friday Conference		$ 40.00	$ 50.00	$
Saturday Conference		$ 60.00	$ 75.00	$
Sunday Conference		$ 85.00	$105.00	$
Whitewater Rafting Trip*	_____x	$ 62.00	not available	$
Bicycle Rental**	_____x	$ 28.00	not available	$
Fallingwater Tour***	_____x	$ 25.00	not available	$
∆Course fees include conference materials, credit, and meals.			Total	$

*Trip includes bus transportation, rafting, and lunch on the river.
**Trip includes bus transportation and rentals. Meals are available for purchase on location.
***Trip includes bus transportation and admission ticket. Meals are available for purchase on location.
∆Course fees include conference materials, continental breakfasts, breaks, and credit.

Credit Card payment: Please charge my ☐ Visa ☐ MasterCard Card number _____

Expiration date _____ Authorization signature _____

FAX registration and credit card payment to **(304) 293-8652** or mail form with payment to:

WVU Foundation
c/o Office of Continuing Medical Education
1250 Health Sciences South
PO Box 9080
Morgantown, WV 26506-9080

Special Requirements: If you require access and parking for the handicapped, please so indicate:

For more information, please contact the WVU School of Medicine Office of CME at 1-800-WVA-MARS or (304) 293-3937.

The West Virginia University School of Medicine is entitled by the Accreditation Council for Continuing Medical Education (ACCME) to award credits in continuing medical education for physicians. The Office of CME certifies that this continuing medical education activity meets criteria for 9 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association.

WEST VIRGINIA UNIVERSITY SCHOOL OF MEDICINE
OFFICE OF CONTINUING MEDICAL EDUCATION

21st Annual Hal Wanger Family Medicine Conference

September 21-23, 1995

Robert C. Byrd Health Sciences Center of West Virginia University
Morgantown, WV

Registration is requested by September 7, 1995.

Name _____ Degree _____
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Specialty _____ Subspecialty _____

Hospital Affiliation(s) _____

Course Fees*	Before Sept. 7	After Sept. 7	Total
Full conference	$195.00	$240.00	$
Thursday and Friday	$165.00	$205.00	$
Friday and Saturday	$150.00	$185.00	$
Thursday only	$100.00	$125.00	$
Friday only	$100.00	$125.00	$
Saturday only	$ 90.00	$110.00	$
Football Tickets (limit 4) WVU vs. Kent State _____x	$ 20.00	$ 20.00	$
*Course fees include conference materials, credit, and meals.		Total	$

Credit Card payment: Please charge my ☐ Visa ☐ MasterCard Card number _____

Expiration date _____ Authorization signature _____

FAX registration and credit card payment to **(304) 293-8652** or mail form with payment to:

WVU Foundation
c/o Office of Continuing Medical Education
1250 Health Sciences South
PO Box 9080
Morgantown, WV 26506-9080

Special Requirements: If you require access and parking for the handicapped, please so indicate:

_____

For more information, please contact the WVU School of Medicine Office of CME at 1-800-WVA-MARS or (304) 293-3937.

The West Virginia University School of Medicine is entitled by the Accreditation Council for Continuing Medical Education (ACCME) to award credits in continuing medical education for physicians. The Office of CME certifies that this continuing medical education activity meets criteria for 14 credit hours in Category 1 of the Physicians Recognition Award of the American Medical Association.

President's Page

A Message...

You see them everyday -- filling your waiting rooms, in the operating room, the hospitals, unexpectedly on the street -- they're your patients. They come in all shapes and sizes, all ages, from the tiny, wrinkled newborn to the frail and aged.

They have varying complaints and illnesses. There's the child with cerebral palsy trying to find his niche in the world, the unwed, pregnant teenager with terrified eyes, the concerned businessman in his 40s with his first twinges of chest pain, to the grandfatherly gentleman whose wife is terminally ill and must face the empty years ahead.

No matter what age, what illness, what concerns they harbor, they all share one common thing -- you are their doctor, their physician, their healer. They look to you, and only you, to help them in their time of need. At that moment, they don't care about health insurance, hospitals, or malpractice suits. It is only you and them.

Unless I'm mistaken, this is why most of us entered this profession -- for these moments when only we, with our skills and expertise, can help these individuals. To reassure them that their tests are okay, to tell them that the pain in their chest is insignificant, to tell them that the operation will improve their condition, and when disease wins despite our best efforts, to be there to comfort them through the difficult times ahead. There is no amount of money or material compensation that can replace this feeling.

Unfortunately, we are increasingly losing touch with this most hallowed moment in the doctor-patient relationship, when healing hands transcend all other concerns, when our thoughtful decisions and actions make the difference. We *must not* allow this to happen. Bureaucracy and administrative interference, from whatever source, be damned.

Doctor, your patient now stands before you, looking for your help, their health in your hands. What will *you* do?

I thank you for a wonderful year. Your fate and that of your patients is in your hands. Farewell and good luck.

Dennie

WESPAC needs you!!

The most recent report from AMPAC shows that only 169 WVSMA members had contributed to AMPAC this year as of May 31, 1995 -- a dramatic drop from this same date last year when 219 WVSMA members had given AMPAC donations. At best, this shows mediocre support. Unfortunately, our WESPAC membership shows the same discouraging decrease.

It is easy to get excited about WESPAC in election years, but we must sustain that excitement and financial support in the off years as well in order to build the campaign war chests we need to achieve our goals.

How can any physician who has had to withstand the incompetence of the Medicaid and PEIA administrations -- their lies to the press and public, their broken promises, their ridiculously low reimbursement fees, their delays in payments, and their badmouthing of our profession -- not see the wisdom of contributing as often and as much as possible to the only PAC which cares about the plight of the West Virginia physician?

Last year at this time, I wrote an editorial in the *Journal* in which I reported that 66 of the 85 candidates that WESPAC endorsed won in their races. Now, more than ever, it is critical to make a contribution to WESPAC so we can maintain this momentum. If we can start 1996 with a large balance, we can increase our amounts for the candidates we want to endorse and boost our political clout further.

In addition to your financial support, it is imperative that we receive more input from you as a member of the WVSMA regarding the activities of WESPAC. We need you to interact more with candidates and help us evaluate which individuals we should support with our funds.

If you, as many others do, believe that the WVSMA should be involved in both the state and national political campaigns, please do the following:

1. Join WESPAC as a Dollar-A-Day member for 1995;
2. Send me your opinions and recommendations about WESPAC;
3. Be sure that your component society has a representative serving on the WESPAC Board; and
4. Be sure that the physician who is serving as your board member attends all the WESPAC meetings.

If every WVSMA member accomplished these four requests, WESPAC would really be a major force in the political arena. The only way WESPAC can continue to grow is to build on the renewed energy and goals that burst forth in 1994. This means giving of yourself in both time and money.

Since we have very few friends in the political arena, we must do all we can if we are to survive as the free-thinking, independent individualists we would like to believe we are.

Join us, please!

Douglas E. McKinney, M.D.
WESPAC Chairman

Three cheers for Darrell McGraw

Our state attorney general may have inadvertently stumbled upon the monetary solution to solve the "Health Care Crisis." If his suit against the tobacco companies is successful, it could open a veritable treasure trove of deep pockets.

Any maker of alcoholic beverages could be held liable for alcoholism and any related disability.

Twinkies, proven to be a good defense for abberant behavior, also cause obesity. Therefore, sue any manufacturer of food or sugar for obesity, diabetes, etc.

The Morton Salt Company would be an obvious target for any cardiovascular type of disorder.

NASCAR has demonstrated that it is feasible to build cars that can allow the driver to walk away from crashes in excess of 200 miles per hour. Automobile makers should begin beefing up their legal staffs.

With enough imagination and the proper legal expertise, we should be able to reduce the cost of medical care to government and individuals to practically zero. All at the expense of democracy and capitalism?

If the legal profession is astute enough to pursue the true "deep pockets," a side benefit should accrue to our profession. There should be such an abundance of legal work that we physicians will seem to be puny targets.

Louis C. Palmer, M.D.
Associate Editor, *West Virginia Medical Journdl*
Bridgeport

Number of SIDS cases can be reduced

West Virginia's Sudden Infant Death Syndrome (SIDS) mortality rate hasn't decreased in the past 10 years, and each year 25 to 30 babies continue to die. However, recent studies in England, Wales, New Zealand and Tasmania have shown that the simple step of having babies lie on their back or side can have a substantial effect in reducing mortality.

In England and Wales, SIDS deaths fell from 1,337 to 442 over a four-year period with a campaign entitled *"Back to Bed."* In Tasmania, SIDS mortality fell from 7.6 to 4.1 in the cohort study group with 70% of the decrease explained by a similar campaign.

The NIH is now sponsoring a program to have babies put to bed on their backs or sides, and is providing free brochures and stickers. Many obstetrical units in the state hand out these items and give advice on this subject. In addition, pediatricians in West Virginia and throughout the nation are actively co-promoting this effort.

Data collected in West Virginia indicates that most of the infants who died of SIDS in the past three years have been found on their tummies rather than in any other position. SIDS occurs much less frequently with first time mothers than mothers with other children because first time mothers seem to heed the advice given about laying their babies on their backs or sides. In fact, the ratio of infants dying from SIDS who were born to mothers with other children versus those who are first-time mothers has doubled within the past 10 years and now stands at more than 4 to 1.

The problem for multiparous mothers is that they often have been advised in earlier pregnancies to lie their babies on their tummies to avoid aspiration. Then, since there were no problems with these infants, they see no reason to change. Also, there are still aunts, neighbors and grandmothers who advise the "old-fashioned" way.

We need all the physicians in the state who see women prenatally or after their babies are born to give advice about lying babies on their backs or sides. In addition, all physicians need to be willing to give good advice to their communities when the opportunity arises.

R. John C. Pearson, M.D.
Professor of Community Medicine
West Virginia University School of Medicine
Morgantown

Special reminders about the use of Floxin

In their case report published in the January 1995 issue of the *West Virginia Medical Journal*, Drs. Espiritu and Walton describe an elderly male with renal insufficiency who was treated for prostatitis with Floxin Tablets (ofloxacin tablets) 300 mgms po bid. The patient developed a rash two weeks into his course and, some time after the full six weeks of treatment, was found to have resolving interstitial nephritis on renal biopsy. His subsequent death was apparently the result of a ruptured thoracic aneurysm.

I should like to bring the following reminders to the attention of health care providers who read this report:

1. The patient described had a pre-treatment creatinine clearance of 31 ml/min. The FDA-approved Floxin package insert's Dosage and Administration section recommends an adjustment to once a day dosing for a patient with this degree of renal functional impairment.
2. The Warnings section of the insert states that the drug "should be discontinued immediately at the first appearance of a skin rash..."

The authors make no mention of concomitant medications or intercurrent acute illness and the details provided do not establish anything more than a possible temporal association between the kidney process identified on biopsy and the prior use of Floxin. Furthermore, a review of the published medical literature from 1985 on identified only one other such association, the cited case of Kamota et al, who, in fact, attributed the renal failure diagnosed to interstitial nephritis caused by *Yersinia pseudotuberculosis* infection.

James B. Kahn, M.D.
Director, Infectious Disease Research
Ortho-McNeil Pharmaceutical
Raritan, NJ

Editor's Note: Please see the following page for a response from Drs. Espiritu and Walton.

Letters to the Editor

Authors respond to letter from Ortho-McNeil

We appreciate the interest of Dr. Kahn and Ortho-McNeil Pharmaceutical regarding our paper describing acute renal failure in a patient receiving ofloxacin. However, we would like to comment further about several points in his letter which appears on the previous page.

We agree with the need to decrease the dose of ofloxacin in patients with renal insufficiency. The package labeling recommends a change in the dosing interval from every 12 hours to every 24 hours in patients with creatinine clearances less than 50 ml/min. However, we are unaware of any literature suggesting that interstitial nephritis from fluoroquinolones, including ofloxacin, is a dose-related phenomenon. Dr. Kahn's second point regarding discontinuation of fluoroquinolones in the presence of a skin rash was clearly stated in the conclusion of our paper.

Our case report did not include the patient's maintenance therapy since we believed it to be non-contributory to the renal dysfunction. Although the patient had chronic drug exposure to labetolol, terazosin and low-dose aspirin, ofloxacin was the only new medication in his drug regimen. We agree that this provides only a temporal and not a causal relationship between ofloxacin exposure and interstitial nephritis, but a rechallenge of the patient was not possible.

In view of the paucity of literature discussing such a relationship between ofloxacin and interstitial nephritis, our paper was meant to alert physicians about this possible adverse effect.

Julian Espiritu, M.D., FACP
Ted Walton, Pharm.D., BCPS

In My Opinion

Aid and comfort

Some time ago, I read an article concerning the use of Zyderm (injectable collagen) for the treatment of fine wrinkle lines around the eyes.

The author described a modification of standard technique in which he uses a fine needle such as a 30-gauge needle instead of the usual 27-gauge, and injects smaller amounts than usual. This is a small technical advance which is somewhat helpful, because in the past, the usual technique left discernable lines of collagen which was unsettling to some patients and some treating physicians.

Zyderm has been available for over 10 years and its use has been fairly common. The original technique is quite similar to any intradermal injection such as a PPD and is not difficult to administer.

The problem arises at the end of the article. The author stated that since this is a new technique, one should have special training before using it on patients. Since he is the first to publish, is he the only one to qualify as an expert? When and where would the training be available?

I have injected these fine lateral eye lines for several years in selected patients. I suppose, now that this article is in print, that if anything goes awry I will not have much defense since I have not had the "special training."

In my opinion, there are too many similar type statements in the literature. The only useful purpose is to give aid and comfort to the legal profession.

Perhaps some effort should be devoted to educate our own that it is unwise to use terms such as "an Xray should always be ordered" or "procedure X should never be done."

Louis C. Palmer, M.D.
Diplomate of the American Board of Dermatology
Associate Editor, *West Virginia Medical Journal*
Bridgeport

Helsley to be installed as WVSMA president

Family physician and WVU Associate Professor of Medicine Dr. James D. Helsley of Morgantown will take the presidential oath of office on Saturday, August 19, at the conclusion of the Second Session of the WVSMA House of Delegates during the WVSMA's 128th Annual Meeting at The Greenbrier.

Dr. Helsley is a native of Berkeley Springs, W.Va., who received his M.D. degree from the WVU School of Medicine in 1977. He completed an internship at Riverside Hospital in Newport News, Va., through the Medical College of Virginia, and also did his residency through MCV at the First Colonial Family Practice Center in Virginia Beach, Va.

After finishing his FP residency in 1980, Dr. Helsley was in private practice in Berkeley Springs for 10 years. For his first four years of practice, Dr. Helsley was also an ER physician at Morgan County War Memorial Hospital. In addition, in 1984 he was appointed medical examiner for Morgan County, and later served as the county's health officer for two years.

While he was still in solo practice in Berkeley Springs, Dr. Helsley began teaching as a clinical assistant professor at Georgetown University Hospital in Washington, D.C., and at Ruby Memorial Hospital at WVU. In 1991, Dr. Helsley joined the faculty of WVU full-time as an assistant professor of family medicine, and the following year he was named Outstanding Teacher of the Year for the Department of Family Medicine. This summer, Dr. Helsley was promoted to associate professor.

Helsley

A member of the WVSMA since 1981, Dr. Helsley began serving on the Council in 1988. The following year, he was elected to the Executive Committee of the Young Physician's Section and later served as a delegate and alternate delegate to the AMA's Annual Meeting. Since 1992, Dr. Helsley has served on the WVSMA's Continuing Medical Education Committee, and in 1993 he was elected vice president of the WVSMA, and then president-elect in 1994. He is also a former president of the Eastern Panhandle Medical Society and is currently president of the Monongalia County Medical Society.

A diplomate of the National Board of Medical Examiners and the American Board of Family Practice, Dr. Helsley is also a fellow of the American Academy of Family Physicians and in 1992 was certified for added qualifications in geriatric medicine. In addition, he is a member of the West Virginia Chapter of the American Academy of Family Physicians and the Pennsylvania-West Virginia Geriatric Society.

Besides teaching and serving on several committees at WVU, Dr. Helsley practices family medicine and geriatrics in Morgantown. Dr. Helsley and his wife, Vickie, who is a member of the WVSMAA and Monongalia County Medical Alliance, have two children.

Special Thanks!!!

The WVSMA staff would like to recognize the members of this year's Annual Meeting Program Committee for the effort put forth by each individual. The time and iniative taken by these members is sincerely appeciated by the staff and all those who have the opportunity to participate in the WVSMA's Annual Meeting:

Phillip R. Stevens, M.D., Chairman

Constantino Y. Amores, M.D.
John F. Brick, M.D.
Sue Bryant, WVSMAA President
Dennis M. Burton, M.D.
Thomas H. Chang, M.D.
James L. Comerci, M.D.
C. Richard Daniel, M.D.
David A. Denning, M.D.
Robert A. Gustafson, M.D.
James D. Helsley, M.D.
John D. Holloway, M.D.
Michael J. Lewis, M.D.
Maurice A. Mufson, M.D.
Stephen E. Perkins, M.D.
David W. Ranson, M.D.
Jose I. Ricard, M.D.
Stephen L. Sebert, M.D.
Mabel M. Stevenson, M.D.

Ex-Officio Members

David Bailey, MBA
CME - Marshall University

Kari Long
CME - WVU, Morgantown

Robin Rector
CME - WVU, Charleston

During General Session

Two speakers to focus on implications, rules, regulations of managed care delivery in WV

"Integrated Delivery Systems - Implications for Physicians" and *"West Virginia Rules and Regulations Concerning Managed Care Entities,"* will be two of the topics featured for this year's General Session, which is entitled *"Medical Potpourri"* and will take place on Thursday, August 17 during the WVSMA's Annual Meeting at The Greenbrier.

As previously reported, this session will begin at 8 a.m. with the lecture *"Evolving Pattern of Crohn's Disease"* by **Robert W. Beart Jr., M.D.**, professor of surgery and colon and rectal surgery at the University of Southern California. Following Dr. Beart's talk at 8:45 a.m., **David E. Schuller, M.D.**, professor and chair of Ohio State University's Department of Otolaryngology, will discuss *'The Diagnosis of Neck Masses: Physical Diagnosis or High Technology?"*

After Dr. Schuller's lecture, a break will be held and then at 10 a.m., **Douglas T. Cardinal**, a manager for Ernst & Young LLP's Central Region Health Care Consulting Practice, will lecture about the different models of integrated delivery systems and the effects on physicians' practices. In conjunction with Mr. Cardinal's talk, **Hanley C. Clark**, the insurance commissioner for West Virginia, will then speak about the state's rules and regulations regarding managed care.

This session will be moderated by Phillip R. Stevens, M.D., who will also conduct an open discussion with the panelists following Mr. Clark's talk.

Information about Drs. Beart and Schuller appeared in the May/June issue, and brief bios on Mr. Cardinal and Mr. Clark begin below. Highlights of this year's WVSMA Annual Meeting are printed on page 210 with a registration form on the opposite page.

Cardinal

Clark

Speakers highlighted

Mr. Cardinal holds a B.A. degree from California State University at Stanislaus and an M.P.A./H.S.A. from the University of Southern California.

Mr. Cardinal has devoted much of his career to the development and operation of joint-venture physician hospital organizations (PHOs) and other advanced provider-based delivery programs. He held executive positions at several major medical centers before joining Ernst & Young LLP as manager of their Central Region Health Care Consulting Practice.

A diplomate of the American College of Health Care Executives, Mr. Cardinal is a member of the Health Care Financial Management Association and the Society of Health Care Planning and Marketing.

Mr. Clark entered state government in 1980 as special assistant to John D. Rockefeller IV, and served in that post until March 1981 when he was named the assistant to former Insurance Commissioner Richard G. Shaw.

In March 1985, Mr. Clark became deputy insurance commissioner. He was then named acting insurance commissioner when Commissioner Wright resigned to become director of the PEIA. Mr. Clark held this position from July 1, 1988 until January 18, 1989, when Governor Caperton appointed him insurance commissioner.

A Huntington native, Commissioner Clark received his bachelor's degree from Marshall University in 1972 with a major in history and a minor in English and business. He graduated from WVU in 1974 with an M.A. in history. Upon completion of his dissertation, Commissioner Clark will have a Ph.D. in university administration.

Flink speaker to present *"Cosmic Adventure"*

In addition to delivering the Edmund B. Flink Address at this year's WVSMA Annual Meeting, Clarksburg native Thomas C. Spelsberg, Ph.D., who is the George M. Eisenberg Professor of Biochemistry at the Mayo Clinic, will also be presenting a program entitled *"Cosmic Adventure: Journey with Light,"* just before new WVSMA officers are installed on Saturday afternoon, August 19 at the Second Session of the House of Delegates.

Dr. Spelsberg is the first Ph.D. to serve as president of the medical staff at the Mayo Clinic, and he is a noted researcher and inventor who has been studying the biochemistry and molecular biology of subcellular processes for the past 25 years. He presently holds several NIH research grants and has been awarded six patents.

Spelsberg

Dr. Spelsberg's topic for this year's Edmund B. Flink Address is *"Genes, Their Replication, Expression and Uses in Medicine."* He will deliver this address at 9:30 a.m. on Friday, August 18 during the First Session of the WVSMA House of Delegates at The Greenbrier.

New WVSMAA leaders to take office at Annual Meeting

In conjunction with the WVSMA's Annual Meeting, the WVSMA Alliance will conduct its Annual Meeting from August 18-19 at The Greenbrier. This year marks the organization's 70th anniversary, and a special luncheon and historical fashion show are planned in addition to the installation of the new officers, special guest presentations, business meetings, as well as social and recreational events.

WVSMAA president Sue Bryant will preside over the business meetings at the convention, and at the conclusion of the Second Session of the House of Delegates, AMAA President-Elect Sandra Mitchell will deliver the oath of office to the new WVSMAA President Linda Elliott of Wheeling. She will also install Amy Ricard, as president-elect; Kathy Fortunato, as vice president; Maureen Ibrahim, as secretary; Janet Sebert, as treasurer; Joy Johnson, as Southeast regional director; Bonnie Fidler, as Southwest regional director; Jerry Crites, as Northeast regional director and Lil Gordon, as Northwest regional director.

Elliott

A brief bio of Mrs. Elliott begins below and more details about the meeting can be obtained by phoning Winnie Morano, executive secretary of the WVSMAA, at (304) 925-0342.

New president highlighted

Mrs. Elliott was born in Denver and traveled extensively while growing up because her father was in the Air Force. She obtained a nursing degree at Marshall University and then began working in Charleston, where she met her husband, Terry, who was in his third-year of medical school at WVU.

The Elliotts were married at the start of Dr. Elliott's fourth year, and after graduation, they moved to Wheeling for his FP residency, where Mrs. Elliott formed an informal group for women whose husbands were in residency training. Later, when Dr. Elliott had completed his residency and was working in the ER, a friend encouraged her to become the treasurer for the Ohio County Medical Society Auxiliary. She soon became very active in this organization and served as treasurer, vice-president, president-elect and president, as well as chair for Doctor's Day, Daffofil Day and AMA-ERF. She has also served as AMA-ERF chairman and president-elect for the WVSMAA.

Mrs. Elliott is currently serving as executive director of the Ohio County Medical Society and is a member of the Junior League of Wheeling. The Elliotts have two daughters, Becca and Ashley.

Harris speaker to lecture at Surgery Section meeting

Robert W. Beart Jr., M.D., professor of surgery and colon and rectal surgery at the USC School of Medicine who will present this year's Thomas L. Harris Address at the WVSMA's Annual Meeting *"Current Management of Chronic Ulcerative Colitis,"* will also be the featured speaker for the WVSMA Surgery Section Breakfast Meeting on Friday, August 18 at 7:30 a.m. The topic of Dr. Beart's lecture for this meeting will be *"Laparoscopic Colon Resection."*

Beart

Dr. Beart is a former president of the American Society of Colon and Rectal Surgeons, who has served on the American College of Surgeons' Commission on Cancer and the Colon and Rectal Advisory Committee of the American Cancer Society. He has co-edited two books and published over 250 chapters and articles, and been an assistant editor for *Geriatrics* and *Diseases of the Colon and Rectum.*

In addition to the Thomas L. Harris Address and his lecture for the Surgery Section, Dr. Beart will also be speaking at the General Session *"Medical Potpourri"* about the *"Evolving Pattern of Crohn's Disease."* Dr. Thomas H. Chang, chairman of the WVSMA Surgery Section, is encouraging all interested surgeons and physicians to attend these three presentations.

To attend the breakfast, phone the WVSMA at (304) 925-0342.

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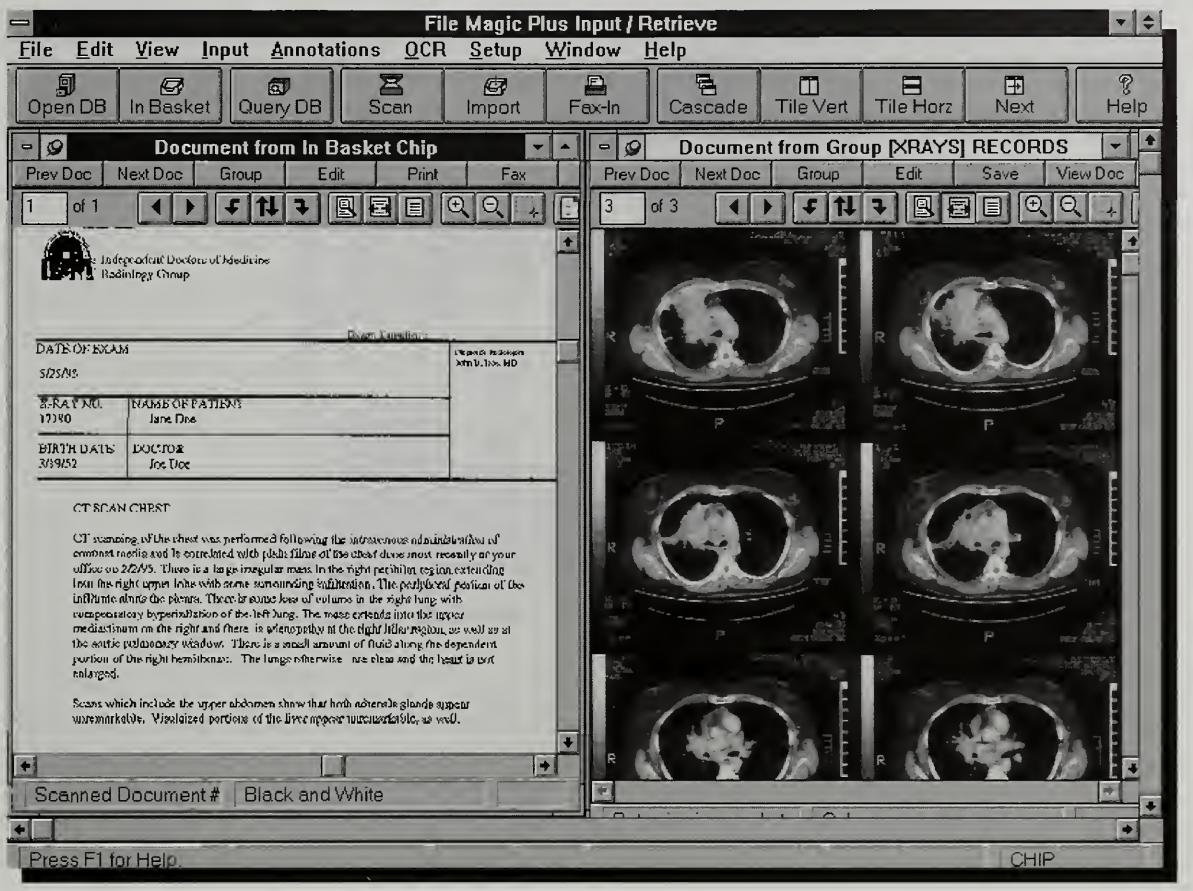

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August 16-19, 1995

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1995 WVSMA Annual Meeting

August 16-19, 1995

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Charleston, WV 25364

Or you may fax this form to (304) 925-0345.

*Conference Cost:	WVSMA member	$125	____
	non-member	$175	____
*Lunch & Learn	**(Thursday, Aug. 17)**		
	physician	$50	____
	spouse/student	$35	____
	(Friday, Aug. 18)		
	physician	$50	____
	spouse/student	$35	____
*Kate's Mountain Outing/Entertainment	**(Friday, Aug. 18)**		____
	couple	$100	____
	single	$50	____
	**Deduct 10% if attending all events*		____
	TOTAL		____

The Greenbrier will fill up quickly because the State Fair will be going on during the same week. For more information, call the WVSMA office at (304) 925-0342. For hotel accommodations, call The Greenbrier at (800) 624-6070.

1995 WVSMA Annual Meeting & Preconvention Highlights
August 15-19

Tuesday, August 15

6 p.m.	WVSMA Executive Committee Dinner/Business Meeting

Wednesday, August 16

9 a.m.	WVSMA Executive Committee Breakfast Meeting
11:30 a.m. - 1:30 p.m.	Executive Committee/Council Luncheon
1:30 - 4:30 p.m.	WVSMA Council Meeting
6:30 - 7:30 p.m.	Presidential Reception hosted by Cabell County Medical Society

Thursday, August 17

7 - 8:30 a.m.	Medical Education Committee Breakfast Meeting
7 - 8:30 a.m.	Component/Specialty Society Presidents' Breakfast
8 a.m. - noon	**General Scientific Session** (Medical Potpourri) "Evolving Pattern of Crohn's Disease," Robert W. Beart Jr., MD "The Diagnosis of Neck Masses: Physical Diagnosis or High Technology?" David E. Schuller, MD "WV Rules and Regulations Concerning Managed Care Entities," Hanley Clark, WV Insurance Commissioner "Integrated Delivery Systems - Implications for Physicians" Doug T. Cardinal, Manager, Central Region Health Care Consulting Practice, Ernst & Young LLP
Noon - 1:30 p.m.	**Lunch and Learn** (limited space) "Medical Ethics and the Rationing of Care," Warren Point, MD AMA president and other visiting dignitaries
2 p.m.	Golf, Tennis and Volleyball Tournaments
4 p.m.	1996 Annual Program Committee Meeting
4:30 p.m.	WESPAC Board Meeting
6:30 - 7:30 p.m.	Reception hosted by Medical Assurance of WV and Acordia of WV

Friday, August 18

7:30 a.m.	**Breakfast Meetings** (times and locations to be announced)
8:30 a.m.	**First Session of the House of Delegates** Edmund B. Flink Address - Thomas C. Spelsberg, MD - "Genes, Their Replication, Expression and Uses in Medicine" Thomas L. Harris Address - Robert W. Beart Jr., MD - "Current Management of Chronic Ulcerative Colitis" WVSMA Presidential Address - Dennis M. Burton, MD - "Reflections"
Noon - 1:30 p.m.	**Lunch and Learn** (limited space) "From Tort deForm to Tort Reform," Ronald Alexander, JD AMA president and other visiting dignitaries
Noon	**Specialty Meetings** Various chapters of West Virginia Specialty Societies are scheduled for luncheon/business and scientific meetings. Times and locations will be noted in the official program.
1:30 p.m.	Resolutions Committee - Open Session
5:30 - 6:30 p.m.	Reception hosted by WVU/MU Schools of Medicine, and WVU
8 p.m. - midnight	Outing at Kate's Mountain - Entertainment provided by Acordia of WV

Saturday, August 19

7:30 a.m.	**Breakfast Meetings** (times and locations will be noted in the official program)
8 a.m.	**Second Session of the WVSMA House of Delegates** Delegate Registration
9:00 a.m.	AMA Presidential Address - Lonnie R. Bristow, MD - "Practice of Medicine in the Changing Environment of Health Reform" Resolutions Election of Officers "Health Problems of Our Presidents," Robert D. Crooks, MD
11:30 a.m. - 1:30 p.m.	WVSMA Component and Specialty Society Presidents, 50-Year Graduates, Past Presidents, and Visiting State Presidents' Luncheon
1:30 p.m.	**Reconvene Second Session of House of Delegates** (business continued) "Cosmic Adventure: Journey with Light," Thomas C. Spelsberg, Ph.D. Oath of Office and Presidential Address - James D. Helsley, M.D. - "The Only Constant is Change"
4:00 p.m.	*Reception honoring newly-installed officers of WVSMA and Alliance

**Time dependent upon adjournment of House of Delegates Session*

1995-96 WVSMA Delegates/Alternates

BOONE (2)
Delegates: Ron Stollings
Alternates: Names not submitted

BROOKE (2) Names not submitted

CABELL (15) Names not submitted

CENTRAL (3)
Delegates: Rigoberto Ramirez, Joseph Reed, Arturo Sabio
Alternate: Clememte Diaz

EASTERN PANHANDLE (4)
Delegates: Edward Arnett
Alternates: Names not submitted

FAYETTE (3)
Delegates: Fred Akerberg, Miraflor Khorshad, Saghir Mir
Alternates: Victoria Timbayan, Adin Timbayan, Enrique Aguilar

GREENBRIER VALLEY (3)
Delegates: Thomas S. Kowalkowski, William Mossburg
Alternate: Stephan Thilen

HANCOCK (3)
Delegates: Charles P. Capito, Antonio Licato
Alternates: Names not submitted

HARRISON (5)
Delegates: Florencia Lopez, Joseph Momen, Saad Mossallati, David Waxman
Alternates: Chinmay Datta, Cordell De La Pena, Erlinda De La Pena, Mehmet Kalaycioglu

KANAWHA (20)
Delegates: M. B. Ayoubi, Nicholas Cassis, Ronald E. Cordell, Alva Deardorff, Michael Fidler, Donald Farmer, Robert Ghiz, Sherman E. Hatfield, Chandra Kumar, Michael Lewis, Tom Linger Jr., Tony Majestro, Jimmie Mangus, John Markey, Samuel Oliver, William Sale, Samuel Strickland, Jose Serrato, Joseph Skaggs
Alternates: L. S. Agrawal, Bruce Berry, Sandra Elliott, Albert Heck, Ted Jackson, M. Z. Khan, Lester Labus, Reginald McClung, Brittain McJunkin, David Ritchie, Ralph Smith, David Sparks, James Spencer, Caroline Williams, John Willis

LOGAN (3)
Delegates: Raymond Rushden
Alternate: Rajendra Valiveti

MARION (4) Names not submitted

MARSHALL (2)
Delegates: Dennis W. Allen, Kenneth Allen
Alternates: Names not submitted

MASON (2) Names not submitted

MCDOWELL (2) Names not submitted

MEDICAL STUDENT SECTION (1)
Delegate: Dominic Cottrell
Alternate: Melissa Matulis

MERCER (5) Names not submitted

MONONGALIA (22)
Delegates: Karen Gerbo-Clark, Anne C. Cutlip, William Cutlip, Robert M. Gerbo, Richard Kerr, Paul F. Malone, James Martin, Bill Neal, John C. Pearson, William Ramsey, Joseph Renn, Stephen L. Sebert, Mary Ann Sens, Jeffrey A. Stead, James Stevenson, Richard M. Vaglienti, Herbert Warden, Dorian Williams
Alternates: Douglas Glover, Stanley Kandzari, David Lynch, David M. Morgan, Stephen Powell, Kimberly Stearns

OHIO (11)
Delegates: Robert Altmeyer, Dennis Burech, Terry Elliott, Michael Fortunato, Barton Hershfield, John D. Holloway, Dennis Niess, Harry Weeks, Daniel Wilson
Alternate: Martin Reiter

PARKERSBURG ACADEMY (8)
Delegates: Harry Amsbary, Bill Atkinson, David Avery, Frederick Gillespie, Robert Gustke, Harry Shannon, Richard Yocum
Alternates: Samuel Guy, Rutherford Sims

POTOMAC VALLEY (2) Names not submitted

PRESTON (2)
Delegates: Darryl Landis
Alternates: Rick Stadtmiller

PUTNAM (2) Names not submitted

RALEIGH (7)
Delegates: Anthony Dinh, Ahmed Faheem, Wallace Johnson, Robert Pulliam, William Scaring, Rajnikant Shah, Norman Taylor
Alternates: Lewis Fox, Prospero Gogo, Cecil Graham, Khalid Hasan, Carlos Lucero, Iligino Salon, Nancy Webb

RESIDENT PHYSICIAN SECTION - (1)
Delegate: Kurt Palazzo

SOUTH BRANCH VALLEY (2) Names not submitted

SUMMERS (2) Names not submitted

TUG VALLEY (2)
Delegates: Rao H. Vempaty
Alternates: Names not submitted

TYGARTS VALLEY (4)
Delegates: Stanley S. Masilamani, Samuel M. Santibanez, Joseph Tavolacci, C. Villaraza Jr.
Alternates: Serge Cormier, Halberto G. Cruz, Elvin G. Kreider, Joung W. Rhee

WESTERN (2) Names not submitted

WETZEL (2) Names not submitted

WYOMING (2) Names not submitted

1995 WVSMA Annual Meeting Exhibitors

Booth 1
Family Medicine Foundation of WV
Chris Ferrell, Alice Jo Hess

Booth 2
AMS Medical Billing Agency
Felicia Adams

Booth 3
Rhone-Poulenc Hospital/Oncology Division
Michael Ball

Booth 4
West Virginia Breast and Cervical Cancer Screening Program
Patricia Hilton

Booth 5
Wheat First Butcher Singer
Linda Smith, Charles Six

Booth 6
Southern Medical Association
Chip Dawson

Booth 7
Ram Technologies
Joe Spano, Bill Synder

Booth 9
Division of Rehabilitation Services - Disability Determination Section
Steve Nicholson

Booth 10
Corning Metpath Clinical Laboratories
Evette Sheppard, Nancy Braenovich

Booth 11
National Financial Services
Steve Hyer

Booth 12
Schering Oncology
Diane Hackney

Booth 13
National Multiple Sclerosis Society, WV Chapter/Berlex
Patty Snodgrass

Booth 14
Automated Professional Accounts, Inc.
Michael D. Mills, Kim Cameon

Booth 15
Bristol-Myers Squibb
Geri Kaufman

Booth 28
Home Care Services and Therapy, Inc.
Christy Walker

Booth 29
West Virginia American College of International Physicians
Victorino Teleron, MD, Jose Canario, MD, Jose Ricard, MD

Booth 30
Associated Physical Therapists, Inc.
Marj J. Weigel

Booth 31
Center for Organ Recovery and Education
Pete Renzi

Booth 32
Medical Practice Financial Management Group
Ruth Wood, Bob Byrd

Booths 33, 34 & 35
WV Bureau for Public Health

Booth 36
Oasis Pain Management Program
Terry Rusin, Stu Porter, Sharon Griffith, Janice Harsha

Booth 37
Wallace Laboratories
Theresa Adkins

Booths 38 & 39
Integrated Document Management

Booth 40
Advanced Benefit Design
William Mucklow

Booth 41
SmithKline Beecham Pharmaceuticals
Jeff Holland, Jon Lipps, Maureen Burke, Doug Wallace

Booth 42
Carelink
John Marks, Susan Cunningham

Booth 43
West Virginia Medical Institute
Harry S. Weeks, MD, Betty C. Kirkwood, Nadine Cogar Goff, Rebecca Fain Cochrane, Mark K. Stephens, MD

Booth 44
Pfizer Labs
Paul Lenz

Booth 45
G. D. Searle
Susan Glover, Steve Quinn, Natalie Egnor-Walker

Booth 46
Hoffman-LaRoche
Ron Goodwin, Tom Mitchell, Becky Vaughan

Booth 47
Benchmark Data Systems
Terri Bailey, Kyle Hawkins, Barry Brooks

Booth 48
U.S. Army Medical Department
CPT. Daniel Goodberlet

Booth 49
BMW Med Tech
Ed Parks

Booth 50
Prime One
James Sturm, Brenda Cappellinni, Richard Sowards, Valorie J. Raines, John Fischer

Booth 51
Glaxo, Inc.
Fayette Thackston

Booth 52
Robert C. Byrd Health Sciences Center of WVU
Joe Antonini

Booth 53
Rhone-Poulenc Rorer Pharmaceuticals, Inc.
Greg Sargent, Samantha Chambers, Ron Hart

Booth 54
Marshall University School of Medicine
Gay Jackson, Beth L. Hammers

Booth 55
Acordia of West Virginia
Mary Bowman Telfer, Heather Sipes

Booths 56 & 57
Medical Assurance of West Virginia, Inc., and Acordia of West Virginia, Inc.
A. Derrill Crowe, MD, Jim Cates, Chuck Ellzey, Steve Brown, Michele Myers, Rob Vass, Tamara Lively

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Join Us For Two Exciting Lunch & Learn Sessions

"Medical Ethics and the Rationing of Care"

Warren Point, M.D. - Keynote Speaker

Thursday, August 17, 1995

noon - 1:30 p.m. - *Crystal Room*

Joining Dr. Point will be the following visiting dignitaries:

- Lonnie R. Bristow, MD - President of the AMA
- Dennis M. Burton, MD - President of the WVSMA
- Robert R. Goodin, MD - President of the Kentucky Medical Association
- Jack L. Summers, MD - President of the Ohio State Medical Association
- Russell E. Evett, MD - President of the Medical Society of Virginia

"From Tort deForm to Tort Reform"

Ronald Alexander, Esq. - Keynote Speaker

Friday, August 18, 1995

noon - 1:30 p.m. - *Crystal Room*

Joining Mr. Alexander will be the following visiting dignitaries:

- Lonnie R. Bristow, MD - President of the AMA
- Dennis M. Burton, MD - President of the WVSMA
- William Cooper, MD - President of the Indiana State Medical Association
- Robert R. Goodin, MD - President of the Kentucky Medical Association
- George S. Malouf, MD - Past President of Medical and Chirurgical Faculty of the State of Maryland
- Jack L. Summers. MD - President of the Ohio State Medical Association
- John H. Hobart, MD - President of the Pennsylvania Medical Society
- Russell E. Evett, MD - President of the Medical Society of Virginia

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WVSMA/WVSMAA TOURNAMENTS

Don't Miss Out on the Annual Meeting Fun!

VOLLEYBALL

Ron D. Stollings, MD, Chairman

T-shirts courtesy Sandoz
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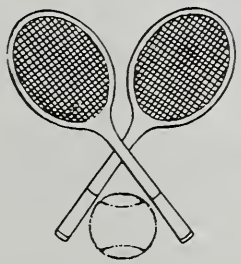
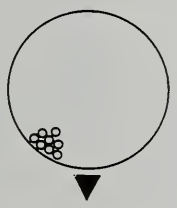
TENNIS



Prospero B. Gogo, MD, Chairman

Trophies courtesy Automated Professional Accounts Inc.

GOLF



Jeffrey Stead, MD, Chairman

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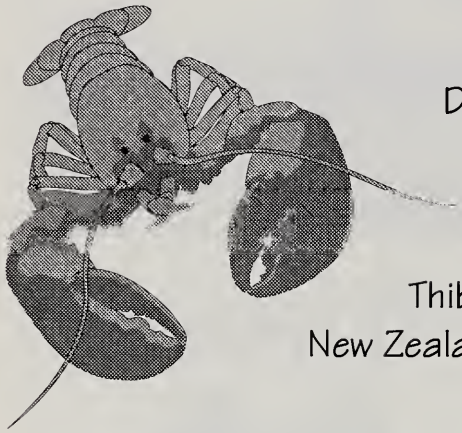
- Golf - For tee time, phone (304) 536-1110 Extension 7172
  If you need additional players, contact Michelle Ellison (800) 257-4747.
- Tennis - Contact Michelle Ellison (800) 257-4747 or register at the WVSMA Registration Desk during the meetings
- Volleyball - Sign up at the WVSMA Registration Desk

All tournaments begin Thursday, Aug. 17 at 2 p.m.

All Exhibitors, Alliance Members, and Annual Meeting Participants are encouraged to get involved!

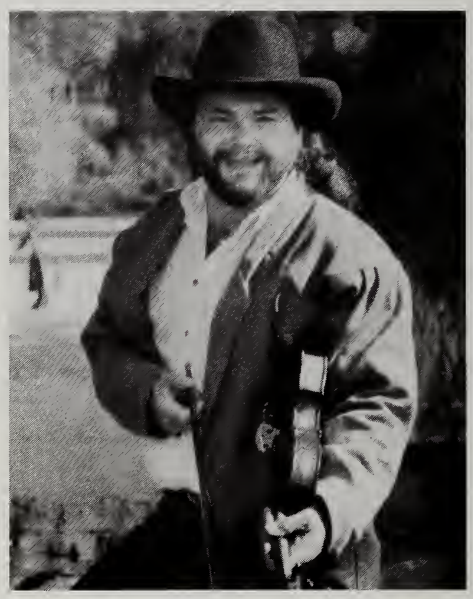
Experience Kate's Mountain

Cajun Style



Don't miss out on the music, food, and fun at this year's Annual Meeting. The scenic Kate's Mountain area of The Greenbrier will be the setting for a special casual evening of entertainment featuring Cajun musician Waylon Thibodeaux, and a buffet-style dinner which includes New Zealand lobster tail, petite filet mignon and all the trimmings.

Waylon Thibodeaux is a French-speaking Cajun, who performs a variety of Louisiana, Cajun and Zydeco music. Known as *Louisiana's Rockin' Fiddler*, Thibodeaux began playing professionally at age 13 and has performed with nationally and internationally renowned musicians and groups such as Tony Orlando, Jo-El Sonnier, Jimmy C. Newman, BeauSoleil and Evangeline and an artist with Mardi Gras Records. In addition to playing at festivals and special events in the U.S. and Canada, Thibodeaux is a popular act at La Strada's Nightclub in New Orleans.



Thibodeaux

Join us for some great food and fun!

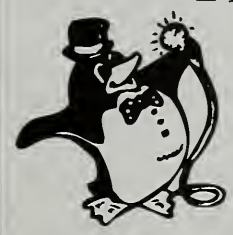
Kate's Mountain, The Greenbrier • Friday, August 18 • 8 p.m. - Midnight • Casual Attire
Entertainment Provided by Acordia of West Virginia

The cost for the evening is $100 a couple or $50 for a single guest. To register for this event and the WVSMA's Annual Meeting, turn to page 211 or phone the WVSMA at (304) 925-0342.

Free limo service to Kate's Mountain will be offered at the front entrance between 7:30 & 7:45 p.m. Tickets must be presented for this service and to attend this event.

Don't Be Left Out on an Iceberg!

Mark your calendar now for the 1996 Mid-Winter Seminars and Scientific Conferences



January 19-21, 1996

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Join us for:

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- Physician/Public Session
- Lunch and Learn
- "Controversies in Medicine"
- "Potpourri of Topics"

The West Virginia State Medical Association's Mid-Winter Sessions will be held in conjunction with the Fifth Annual Scientific Meeting of the West Virginia Chapter of the American College of Physicians. Call the WVSMA at (304) 925-0342 for more information.

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state and region. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your organization for physicians printed in the *Journal*, please contact Nancy Hill, managing editor, at 925-0342.

Charleston Area Medical Center - Charleston

August 5
"Cardiology in the 90s: Challenging the Rapids"

September 7
(Teleconference) "Hormone Replacement Therapy," Ward W. Maxson, M.D.

September 16
"Cancer Pain Role Model Conference," Days Inn, Flatwoods

September 16
"Renal Challenges"

September 29
"Tenth Annual Trauma Conference," Glade Springs Resort, Daniels

Huntington Medical Community Foundation - Huntington

August 8
"EMTALA Legislation," David Hinchman, D.O., Paul Smith, J.D., and Patricia Stultz, R.N., Lawrence County Medical Center, Ironton, Ohio, 6:30 p.m.

August 14
Differential Diagnosis of the Red Eye," Michael Krasnow, D.O., Three Rivers Medical Center, Louisa, Ky., 6:30 p.m.

August 15
"Interventional Radiology," Michael Korona, M.D., Logan General Hospital, Logan, noon

August 17
"TB/AIDS Update," Lu Gillispie, Infection Control, St. Mary's Hospital (speaking for the Williamson Memorial Hospital Medical Staff Meeting), The Brass Tree Restaurant, 6:30 p.m.

September 7
"TBA," Putnam General Hospital, 7:30 a.m.

September 13
"The Role of Stereotactic Breast Biopsy in the Evaluation of Mammographic Abnormalities," James Morgan, M.D. (speaking for the Logan County Medical Society Meeting), Logan, 6 p.m.

September 19
"Utilization Management," Valerie Hopkins, R.N., M.S.N., C.P.H.Q., Williamson Memorial Hospital, Williamson, 6:30 p.m.

September 21
"Impact of Medical Problems on Patient and Family Behavior," Rev. Gary L. Patton, Ph.D., Pleasant Valley Hospital, Point Pleasant, noon

September 26
"Osteoporosis," TBA, Paul B. Hall Regional Medical Center, Paintsville, Ky., 7 p.m.

September 26
"Chronic Pain Management," TBA, South Williamson Appalachian Regional Hospital, South Williamson, Ky., 6 p.m.

Robert C. Byrd Health Sciences Center of WVU - Morgantown

August 25-27
"Second Annual Primary Care Perspectives on Women's Health"

September 9
"Otolaryngology for Primary Care"

September 21-23
"21st Annual Hal Wanger Family Medicine Conference"

September 30
"The Inaugural Mountainview Vascular Society Meeting"

West Virginia State Medical Association - Charleston

August 16-19
"WVSMA's 128th Annual Meeting," The Greenbrier, White Sulphur Springs

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Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *Charleston Area Medical Center, Charleston*

Elkins ★ Davis Memorial Hospital, August 15, 6:30 p.m., "Antibiotic Resistance," Stephen Aronoff, M.D.

Fairmont ★ Fairmont Clinic, August 16, 1 p.m., "Managing Low Back Pain," John Coumbis, M.D.

★ Fairmont Clinic, September 20, 1 p.m., "Dietary Lipid Counseling," Robert Hoeldtke, M.D.

★ Fairmont General Hospital, August 1, 7:30 p.m., "AIDS/HIV Infection," R. Wesley Farr, M.D.

Man ☐ Man Appalachian Regional Hospital, August 16, 6 p.m., "Diagnosis and Management of Thyroid Disorders," Steven A. Artz, M.D.

Montgomery ☐ Montgomery General Hospital, August 2, 12:30 p.m., "Critical Care Pharmacology," Laura Welch, Pharm.D.

New Martinsville ★ Wetzel County Hospital, August 10, noon, "Diabetic Nephropathy" Rebecca Schmidt, M.D.

★ Wetzel County Hospital, September 14, noon, "Update on Adult Immunizations" Raymond A. Smego, M.D.

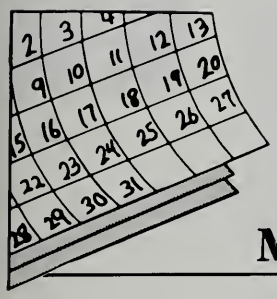
Petersburg ★ Grant Memorial Hospital, August 22, noon, "New Developments in the Treatment of Sinus Disease," Hassan Ramadan, M.D.

Point Pleasant ☐ Pleasant Valley Hospital, August 24, noon, TBA

White Sulphur Springs ★ The Greenbrier Clinic, August 28, 4 p.m., "Coronary Artery Bypass Surgery - A Current Status," Ronald C. Hill, M.D.

★ The Greenbrier Clinic, September 25, 4 p.m., "Returning the Injured Worker: Principles/Caveats, John Coumbis, M.D.

**TBA - To Be Announced*



Medical Meetings

August

4-6–Pediatric and Adolescent Medicine (sponsored by SMA), Sea Island, Ga.

8-12–Wilderness Medical Society, Aspen, Colo.

13-16–Midwest Surgical Association, Traverse City, Mich.

14-16–Frontline Healthcare Workers: National Conference on Prevention of Sharps Injuries and Bloodborne Exposures (co-sponsored by the Centers for Disease Control and Prevention and the American Conference of Governmental Industrial Hygienists), Atlanta

16-18–Chronic Disease Congress '95 (sponsored by International Business Communications), Denver

16-19–WVSMA's 128th Annual Meeting, White Sulphur Springs

18-20–Dermatology Update (sponsored by SMA), Naples, Fla.

September

5-10–American Academy of Neurological and Orthopaedic Surgeons, Las Vegas

6-8–American Gynecological and Obstetrical Society, Napa Valley, Calif.

6-9–Surfaces in Biomaterials '95 (sponsored by the Surfaces in Biomaterials Foundation), Minneapolis, Minn.

8-10–American Psychiatric Association's Textbook-Based CME Conference, Washington, D.C.

8-14–American College of Radiology, Boston

9-13–1995 Healthcare Solutions Summit (sponsored by Medicode, Inc.), Indian Wells, Calif.

11-14–American College of Emergency Physicians, Washington, D.C.

14-16–American Academy of Facial Plastic and Reconstructive Surgery, New Orleans

16-22–College of American Pathologists, New Orleans

17-20–American Academy of Otolaryngology -- Head and Neck Surgery, New Orleans

21-24–American Academy of Family Physicians, Anaheim, Calif.

24-27–Ortho and Sports Injuries Review (sponsored by the MRI Education Foundation, Inc.), Atlanta

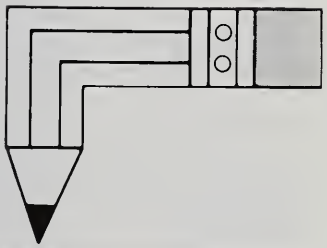
25–1995 Medical Billing Seminar (sponsored by the WVSMA), Flatwoods

29-Oct. 2–Comprehensive Gynecology (sponsored by the Center for Bio-Medical Communication), New York City

29-Oct. 3–American Academy of Environmental Medicine, Tucson, Ariz.

For More Information . . .
Contact the Journal at (304) 925-0342

Poetry Corner



The Thrombins

The following piece was inspired by a biochemistry lecture on the blood clotting cascade. It is a spinoff of the Dr. Seuss story The Sneetches -- with sincerest apologies to Theodore Geisel.

Far, far away in the land of Blood Clottin'
lived the Glu-tailed Thrombins
and the Gla-tailed Thrombins.
Now the Gla-tailed Thrombins
well, they were really hoppin'.
But all was not well with the Glu-tailed Thrombins,
They just kept DROPPIn'
and DROppin
and droppin.

Until one day,
when along came genetic scientist McKeen
with her wondrous DNA fixer-upper machine.
She called to the thrombins, her eyes all-a-gleam
"Attention, you poor feeble Glu-tailed Thrombins,
I'm her to stop your populations from droppin'."

"It seems you are plagued by a poisonous problem,
and insidious Warfarin inhibits you from hoppin'
about like the gleeful Gla-tailed Thrombins."

"Why for just a small price,
step into my machine,
and it'll carboxylate your tails.
Do you get what I mean?"

"And if that's not enough why, for a small price more
I'll add surplus Vitamin K so that you can ensure
that those bellicose warfarins don't plague you anymore."

So, one after another those glu-thrombins streamed
up to the platform of the fixer upper machine.
And, genetic scientist McKeen was broadly smilin'
for those small fees were rapidly pilin'.

And one after another those glu-thrombins streamed
Out of the DNA fixer upper machine
Proudly displaying their new **gla** -- tails
Exclaiming *"Now our calcium bridges will never fail."*

Swati Avashia, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Bureau for Public Health News

This page of material is submitted and paid for by the Bureau for Public Health.

Physicians urged to remind home patients about waste disposal

More than 100 hypodermic needles were recently found in a dumpster in Putnam County, which has prompted state health officials to encourage physicians to remind their patients receiving medical treatment at home about the proper disposal of needles and other medical waste.

Joseph P. Schock, director of the Office of Environmental Health Services of the West Virginia Bureau for Public Health, says medical waste such as used needles can be a major cause of infectious diseases and proper disposal is extremely important.

Schock says needles and other sharps thrown out in plastic garbage bags cause numerous solid waste worker injuries and could also be a tragic consequence of childhood curiosity. He says even if materials aren't contaminated with infection, individuals coming in contact with the waste don't know this and are greatly concerned for their own health.

Schock's office has developed guidelines for the disposal of home health care waste, which are contained in a free brochure, *"A Household Guide for the Proper Disposal of Syringes and Sharps."* Copies are available for doctors' waiting rooms and other health care facilities.

To receive a copy of this brochure or obtain more information, call (304) 558-2981 or 1-800-922-1255.

Report examines 23 types of cancer in WV

"Cancer in West Virginia - 1993", a new report from the West Virginia Bureau for Public Health, is enabling health care professionals for the first time to examine the occurrence, death rates, stages, and diagnosis of 23 types of cancer.

This is the third year such data has been available for cancer of the female breast and cervix, but the first year it has been available for other types of the disease. According to Beverly Keener, coordinator of the Bureau's Cancer Registry, this data will help determine the best use of resources for prevention and early detection of cancer.

"We know that cancer is the second leading cause of death in the state, taking the lives of 4,729 residents in 1993," Keener said. "Cancer also causes devastating illness in thousands of other West Virginians who survive it. Now we can look at what types of cancer are more prevalent and better decide how to use our resources for prevention and early detection."

Keener says promoting healthier lifestyles could prevent many cancers and deaths in West Virginia. She stated that early detection and treatment can also cure many types of cervical, breast, prostate, colon, uterine, oral and skin cancers, and that assuring access to proper cancer screening and treatment in the early stages of the disease can significantly reduce its prevalence. As more data is collected, areas in the state with unusual occurrences of cancer will be identified and targeted for assistance.

The most commonly diagnosed cancer among West Virginia men in 1993 was cancer of the prostate, while among women it was cancer of the breast. Lung cancer was the second most common cancer diagnosed among both men and women, while colon cancer was third. For all cancers, 7,984 cases of invasive cancer were newly diagnosed in West Virginians in 1993, meaning that for every 100,000 state residents, 332.2 were diagnosed with invasive cancer. The rate was 392.2 for men and 294.9 for women. The vast majority of cancers are diagnosed in individuals over the age of 45.

Nationally, the state ranks 15th highest for men and 16th highest for women in cancer-related mortality. Lung cancer was the leading cause of cancer-related deaths in the state in 1993, with men at least three times more likely to die from lung cancer than from other cancers. Women are more than twice as likely to die from lung cancer than from breast cancer, which is the second most common cancer-related cause of death among women.

For more information or for a copy of the report, call Beverly Keener at (304) 558-5358 or 1-800-423-1271.

"Public Health - - A Silent Miracle, A New Vision"

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WEST VIRGINIA UNIVERSITY HEALTH SCIENCES CENTER

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

Betty Puskar Breast Care Center to open this fall at WVU

Schreiman

The new Betty Puskar Breast Care Center at the Health Sciences Center will be the only facility of its kind in the state when it opens this fall to provide women with comprehensive, all-encompassing breast care.

"Our patients will be cared for by highly qualified health care professionals and have access to educational tools and technology aimed at the prevention, early detection and treatment of breast cancer," said Dr. Judith Schreiman, director of the center.

Although construction of the Breast Care Center won't be completed until around September, the staff is in place and providing care. The team is made up of surgeons, radiation oncologists, diagnostic radiologists, medical oncologists and nurses. They will offer comprehensive diagnostic services, such as mammography and ultrasound; breast health education; psychological support services; treatment; and educational programs.

When the facility opens, a diagnostic procedure called a stereotactic breast biopsy, which was previously not available in North-Central West Virginia, will be offered for patients. This non-surgical procedure offers women an alternative to a surgical breast biopsy, and according to Dr. Schreiman, is very accurate and has excellent cosmetic results.

The center is named for Betty Puskar, a Morgantown philanthropist, who donated $1 million to fund the 5,500 square-foot facility. It will be located next to the Mary Babb Randolph Cancer Center and is accredited by the American College of Radiology.

Linton, Starling head WVU/CAMC board

Linton

Starling

John Linton, Ph.D., associate professor of behavioral medicine at the Charleston Division, has been named chair of the joint WVU/Charleston Area Medical Center Institutional Review Board for the Protection of Human Subjects.

Kenneth Starling, M.D., professor of pediatrics at Charleston Division, will be serving as vice chair.

Radiology training center dedicated

The Department of Radiology dedicated the Ian W. Marshall Training Center, an academic resource and training center for radiology residents, on May 5.

Located in a renovated area of the old University Hospital, the center was dedicated in honor of the late Ian W. Marshall, M.D., a 1989 graduate of the WVU School of Medicine. Dr. Marshall is the son of Dr. Robert Marshall and Dr. Mabel Stevenson of Huntington.

To contribute to the Ian W. Marshall fund, contact the School of Medicine Development Office at 293-3980.

Khakoo named fellow, distinguished teacher

Dr. Rashida Khakoo, section chief of infectious diseases, has been named a Fellow of the Executive Leadership in Academic Medicine Program for Women.

Dr. Khakoo is one of 25 women selected for this honor.

Prescott appointed leader of AACEM

Prescott

Dr. John Prescott, chair of the Department of Emergency Medicine, has been named president-elect of the Association of Academic Chairs of Emergency Medicine.

In addition to his role with the AACEM, Dr. Prescott also serves as state EMS director.

Wax inducted as fellow, presents two papers

At the annual meeting of the American Society of Head and Neck Surgeons, Dr. Mark Wax, assistant professor of otolaryngology, was inducted as a fellow of the society.

Dr. Wax also presented two papers at the annual meeting of the American Academy of Facial Plastic Reconstructive Surgery, *"Sternocleidomastoid Muscle Flaps - - Their Uses in Head and Neck Reconstruction"* and *"Porous Polyetheylene Impacts in Orbital Reconstruction."*

Beattie becomes chair of NIH study section

Diana S. Beattie, Ph.D., professor and chair of biochemistry, has been named chair of the Physical Biochemistry Study Section, Division of Research Grants at the National Institutes of Health. Her term will run until June 30, 1997.

In Memoriam

Please turn to page 236 for obituaries of **Dr. William G. Klingberg**, one of the founding members of the WVU School of Medicine faculty, and **Dr. Edward H. Stullken Jr.**, chair of the WVU Department of Anesthesiology.

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Marshall University School of Medicine

MARSHALL UNIVERSITY

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

New needle biopsy device offers many benefits for patients

A stereotactic core needle biopsy system recently installed at Marshall is allowing many women who may have breast cancer to get quick, accurate test results without the pain and activity limitations of surgery.

"It's unreal; you walk out of the office more or less feeling like you've had some shots," said Mary Adkins of Milton, who had two biopsies done this spring using the new device. "Now you can't even tell anything was done. It's almost too good to be true."

"This procedure is appropriate for women whose mammograms show abnormal areas that cannot be felt," said Dr. James Morgan of MU's Department of Surgery. "It is an accurate method for doing a biopsy without making a big surgical incision. "Since we need only a quarter-inch nick in the skin, there is less scarring."

The stereotactic core needle biopsy system device links mammography capabilities with a computer guidance system. First, the mammographic device X-rays the suspicious area from two angles. The surgeon marks the point he/she wants to sample on the X-rays, and the computer calculates the coordinates that allow the doctor to guide the biopsy needle to the right spot. The outpatient procedure uses local anesthesia and takes about an hour. Patients get their test results in less than a week.

There is no comparison between the new needle biopsy and an open biopsy, according to Adkins, who is a veteran of both procedures.

"With the surgery, you are hindered so much longer," she said. "There were restrictions on driving, and they told me not to lift anything for four to six weeks. With the needle biopsy, they just told me not to lift anything for a couple of days. My husband and I went out to dinner the next evening."

In addition to its other benefits, biopsies with the new machine cost less than half as much as surgical biopsies. Dr. W. Phil Evans of Baylor University has said that use of this technique nationwide could produce savings of up to $1 billion annually.

MU medical center under construction

On May 30, Marshall and Cabell Huntington Hospital began building the $30 million Marshall Medical Center adjacent to Cabell Huntington.

Phase I, now underway, is a $4.5 million Center for Rural Health that will serve as the hub for the school's rural outreach activities. It will also house a medical library, the Rural Health Research Institute, and medical education/conferencing areas.

Phase II, the Clinical Practice Center, will begin once approval is received from the West Virginia Health Care Cost Review Authority. The $25 million facility will improve patient access and lower health costs by bringing together Med School physicians who now care for patients at 10 sites in Huntington.

Funding for the Center for Rural Health comes from the U.S. Department of Housing and Urban Development, and the outpatient center is being funded by Cabell Huntington Hospital, University Physicians & Surgeons, and the Marshall University Foundation.

Mufson named APM president-elect

Mufson

Dr. Maurice A. Mufson, founding chair of Marshall's Department of Medicine, became president-elect of the Association of Professors of Medicine on July 1.

The APM is the the national group of the chairs of departments of internal medicine. As president-elect, Dr. Mufson's duties will include planning the APM's annual meeting, usually held in March.

Savory elected to state, national posts

Savory

Dr. Linda M. Savory, professor of family practice, has been elected president of the Southern Group on Educational Affairs of the Association of Medical Colleges.

Dr. Savory will become president of this group in November, and she has also been elected secretary of the West Virginia Chapter of the American Academy of Family Physicians.

Thirteen honored at graduation ceremony

Two faculty members, two residents and nine students were honored during this year's graduation activities.

Students presented Outstanding Clinician awards to Drs. Oliver Roth and Moniramia Krishnamurthy, and named Drs. Carla Sweeney and Todd Gress as outstanding residents.

The graduates receiving awards were:

- **Erich R. Heinz - Proctorville, Ohio** (Bertha and Lake Polan Award for highest academic standing; and CIBA-Geigy Award, given by classmates to the graduate they believe represents the ideal physician;
- **Kevin S. McCann - Chapmanville** (Upjohn Achievement Award, given by faculty to the student they believe exemplifies the highest attributes of physicianhood;
- **Robert E. Jones III - Ranson** (Bettye and Albert Esposito Award for community service; and Fuller Albright Award (endocrinology);
- **R. Allen Young - Hamlin** W. Edwin Black Award for promise as a rural physician;
- **Kevin M. Kurey - Bethany** Gastroenterology Award; and
- **Leigh Anna Meeks - Romance** Thomas G. Folsom Award (pediatrics)

1995 Medical Billing Seminar

A comprehensive half-day seminar for persons responsible for filing claims in physicians' offices

September 25, 1995

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Program Location and Information:

- Days Inn Flatwoods, WV
- Registration at 8:30 a.m. Seminar at 9 a.m. - 12:30 p.m.
- Registration fees $35 per person (members/member's office staff)
- $55 per person (non-members/office staff)
- Fees include workshop material and two refreshment breaks.

Space is limited so register early! Return the registration form along with fee by September 18. Or fax your form to WVSMA at (304) 925-0345 and mail payment. If you have any questions call (800) 257-4747 or (304) 925-0342.

Sponsored by the West Virginia State Medical Association

1995 Medical Billing Seminar Registration Form

Name of Attendees _____ WVSMA member ($35) _____

_____ Non-member ($55) _____

Physician Name _____ Payment by: Check ___ Visa ___ Mastercard ___

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Mail form with total registration fee to: Tim Allman/WVSMA, P.O. Box 4106, Charleston, WV 25364-4106

Alliance News

AMAA Meeting "jam packed" with business

It was a rewarding experience for Linda Elliot, WVSMAA president-elect, Amy Ricard, WVSMAA president, and I to serve as delegates at the AMA Alliance Annual Convention in Chicago in June (Alice Jo Hess served as an alternate delegate). This year, the convention was condensed into three "jammed packed" days in order to be more fiscally responsible.

The following resolutions were passed by the House of Delegates regarding health issues:

1. AMAA encourages state and county alliances to urge physicians to advise their patients of the addictive potential of gambling; and to urge states which operate gambling programs to provide a fixed percent of their revenue for education, prevention and treatment of gambling addiction; and to urge states which operate gambling programs to affix to all lottery tickrts and display at all lottery ticket computers a warning sign such as "You may become addicted to gambling!"
2. AMAA will petition Congress to recognize the third week in April as "Gun Safety Awareness Week;" and will promote and encourage county and state alliances to initiate programs focusing public attention on gun safety as opposed to gun violence; and petition local governments to establish the third week in April as "Gun Safety Awareness Week."
3. AMAA advocates programs to educate children and adolescents about the incidence and causes of violence, and to teach conflict resolution skills and alternatives to violent behavior; and encourages state and county alliances to support and develop such programs.

Some of the highlights of the Ninteen Point Strategic Plan that were passed are as follows:

- States and counties are encouraged to participate in a unifying, national health promotion in addition to programs that meet local health needs, with the first one being SAVE: Stop America's Violence Everywhere, which should include a violence-free day on the 2nd Wednesday in October, beginning October 11, 1995. National media coverage and a celebrity spokesperson will be obtained by AMAA, and materials are available from national on specific ways for local alliances to participate.
- State and county alliances are strongly encouraged to make information on national programs and activities available at every meeting; a box in *Newsline* will highlight national programs and activities, and these items may be reprinted in local publications; and each state and county leader is strongly encouraged to share with other members information received through newsletters, publications, meetings, etc.
- State and county membership chairs will be invited to a one-day training session in membership development at Confluence II at their own expense, with the first one to be held in February 1996.

I take great pride in the accomplishments of the AMAA and WVSMAA, and I think every Alliance member should be proud to be a part of these two organizations which do so much to improve the health and well-being of the citizens of our country and state. Again, I want to thank each and every one of you for making this such a productive and special year for me as your president. I look forward to seeing you at The Greenbrier for our Annual Meeting!

Sue Bryant
WVSMAA President

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Right where we want to be

"The AMA and America's physicians are right where we want to be" was the message at the AMA's Annual Meeting in Chicago, June 11-15. In conjunction with this meeting, the Seventeenth Annual Assembly meeting of the AMA Medical Student Section was conducted June 15-18, and I was fortunate to attend this meeting with three other WVSMA-MSS members.

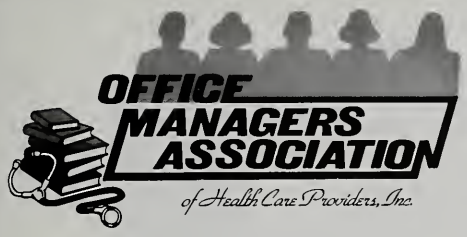
Marshall University was represented by MU Chapter president Mary Jo Martin, and vice-president Mary Rose Boehme. Both of these leaders are rising second-year students who became interested in organized medicine during the course of their first-year in medical school. Melissa Matulis, vice president of the WVSMA-MSS Executive Council, and I represented West Virginia University, both as Council officers and local chapter members of the Morgantown and Charleston campuses. Two seats remained vacant this year for a delegate and alternate delegate from the West Virginia School of Osteopathic Medicine. We are planning now to complete our representation at the Interim Meeting of the AMA in Washington, D.C., in December to include WVSOM students.

The winds of change were not blowing quite so briskly this year in the Windy city compared to last year. Since the political climate has cooled down, the House of Delegates meetings were much less stressful this year, and debates on the floor were much less controversial. For example, much of the legislative work involved social and medical issues such as domestic violence, alcholism, counseling and women's health. Moreover, workforce planning, medical education and residency allotments were treated mildly with short, succinct resolutions which did not adversely affect the MSS's stance on these issues. Many of the topics from Annual Meeting '95 will be discussed in greater detail at the August 5 meeting of the WVSMA-MSS Executive Council at the WVSMA office in Charleston.

At this time, I would also like to remind all the WVSMA-MSS members that the WVSMA's Annual Meeting at The Greenbrier will take place August 16-19. This is a great opportunity for you to get involved and learn more about organized medicine. A special highlight of the meeting will be an address by AMA President Dr. Lonnie Bristow entitled *"Practice of Medicine in the Changing Environment of Health Reform"* on Saturday, August 19 at 9 a.m. during the Second Session of the WVSMA House of Delegates. Melissa Matulis, MSIII, and I will represent the MSS at the meeting and we hope to see many of you there. To register, fill out the form on page 211 in this issue of the *Journal* and return it as soon as possible, or phone the WVSMA at 1-800-257-4747. There is no fee for medical students to attend this meeting!

If you have questions about the WVSMA-MSS, please contact me or Donna Webb at 925-0342 or 1-800-257-4747.

Dominic Cottrell, MSIV
WVSMA-MSS President



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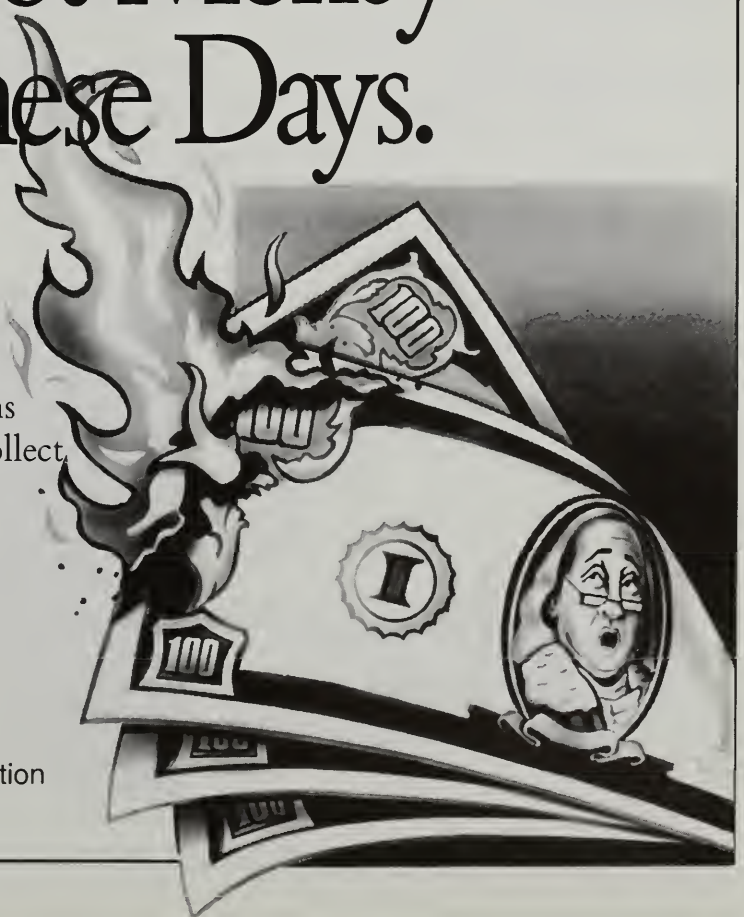

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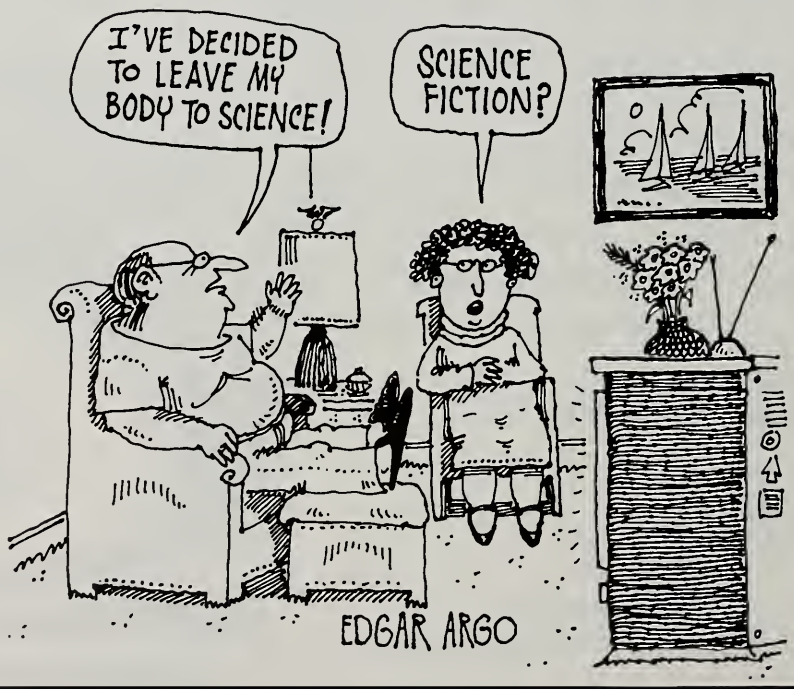

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WESPAC Annual Business Meeting

Thursday, August 17 at 4:30 p.m.

Pierce Room at The Greenbrier

Guest Speakers:

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- Thomas Payne, M.D. - Member of AMPAC's Board of Directors

Important Agenda Item: Should WESPAC endorse gubernatorial candidates?

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Contributions for WESPAC/AMPAC are not deductible as charitable contributions for federal income tax purposes. A portion of your WESPAC contribution is sent to AMPAC thus enrolling you as an AMPAC member as well.

William G. Klingberg, M.D.

Dr. William G. Klingberg, 78, of Tulsa, Okla., formerly of Morgantown, died May 25 at his home due to heart failure.

Dr. Klingberg was born on September 17, 1916, in Wichita, Kan. He graduated from Wichita State University and from the School of Medicine at Washington University in St. Louis. After completing his internship and residency at St. Louis Children's Hospital, he remained on the staff at the hospital and was elected a fellow of the American Academy of Pediatrics.

From 1945-47, Dr. Klingberg served in Korea and retired from the U.S. Army Reserves as a lieutenant colonel. He then lived for a time in Ankara, Turkey, when he was invited by the Turkish government to help establish the first Childrens' Hospital for that nation. Since that time, the hospital he helped to create has developed into the large, multipurpose Hacettepe University which granted him an honorary doctorate of science in 1983.

In 1960, Dr. Klingberg relocated to West Virginia to become the first chairman of the Department of Pediatrics at West Virginia University, and he is considered by his patients and peers as the father of pediatrics in the state. During his tenure, Dr. Klingberg began the Pediatric Group Practice, a comprehensive outpatient service for children, which was one of the first such programs in a teaching institution. He also developed Camp KnoKoma, one of the first camps for diabetic children in the nation. The William G. Klingberg Child Development Center, named in his honor at West Virginia University, provides child development services throughout the state.

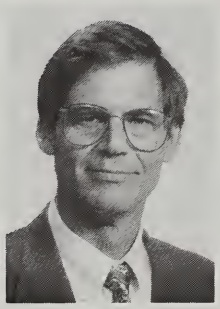
When he retired from WVU in 1987, Dr. Klingberg moved to Tulsa, Okla., where he was a clinical professor at the University of Oklahoma Medical School-Tulsa. In this position, he supervised medical students and interns in the pediatric clinic.

Dr. Klingberg had been a member of the WVSMA since 1962 and he was also a member of the medical honorary society Alpha Omega Alpha. In addition, Dr. Klingberg was a member of the choir at Southminster Presbyterian Church and, when his health permitted, a member of the TJC community chorus.

Surviving are his wife, Rita J. Payton; a son, William Klingberg of Noblesville, Ind.; three daughters, Judith Palmer of Morgantown, Susan "Toni" Burton of Farmington Hills, Mich., and Gloria Payton of Tulsa; four granddaughters, Karen Palmer, Alyssa Burton and Katelyn Gogets; and three grandsons, Robert and Lucas Klingberg and Zachary Burton. He was preceded in death by his first wife, Barbara Jean, and his youngest son, John David Klingberg.

Memorial contributions may be made to West Virginia University Foundation Inc. for the Department of Pediatrics (fund 2V024), 3168 Collins Ferry Road, P.O. Box 4533, Morgantown, W.Va 26504, or to a charity of personal choice.

Edward H. Stullken Jr., M.D.



Dr. Edward H. Stullken Jr., 47, chair of the Department of Anesthesiology at the West Virginia University School of Medicine, died May 11 at his home in Sewickley, Pa., of pancreatic cancer.

Dr. Stullken was born in Oak Park, Ill., in 1947. He earned a bachelor's degree from DePauw University and his M.D. from the University of Illinois. He completed a residency in anesthesiology at the University of Iowa, and a fellowship in neuroanesthesia at the Mayo Clinic.

From 1976-78, Dr. Stullken served in the U.S. Navy as a staff anesthesiologist in Bethesda, Md. Following his military service, Dr. Stullken joined the faculty of Bowman Gray School of Medicine in Winston-Salem, N.C. He taught at Bowman Gray until 1987, when he accepted a post with the Department of Anesthesiology at the University of Pittsburgh.

In 1990, Dr. Stullken joined the faculty of West Virginia University as chair of the board of directors of the faculty practice plan and as medical director of the operating room at Ruby Memorial Hospital. At WVU, he also served as medical director of the Integrated Provider Network, an organization based at the university which contracts with managed care companies.

"Ed was a brilliant and unconventional person who loved a good time, but who also was deeply concerned about the serious issues facing health care today," said Robert M. D'Alessandri, M.D., dean of medicine and vice president for health sciences at WVU. "Ed always knew how to make the most of life, whatever the circumstances. During this final year of his difficult illness, his courage, good humor, and honesty were unforgettable," said Dr. D'Alessandri.

Dr. Stullken was an excellent teacher, and several times met with medical students to talk candidly about his experiences as a patient with a terminal illness. "There is a difference between curing and healing," he told them. "Even when you can't cure, you can be a healer. Especially when an illness is terminal, a patient wants and needs to be engaged as a fellow human being."

West Virginia University recently established an endowed fund to support "The Edward H. Stullken Jr. Lectureship: New Directions in Medicine." Dr. Stullken attended the first of these annual events in March, and was joined by many of his family members and current and former colleagues.

Dr. Stullken was a member of numerous associations, including the Society of Anesthesia Educators, the American Association of Neurologic Surgeons, the Congress of Neurological Surgeons, the AMA, the International Anesthesia Research Society, the Society of Neurological Anesthesia and Neurological Supportive Care, and the American Society of Anesthesiologists. He was active in the Roman Catholic Church and many outreach programs.

Surviving are his wife, Emelia ("Mimi"), and by three children, Anne Catherine, 20, Matthew Edward, 15, and John Vincent, 9.

The family has requested that any donations in his memory be made to Habitat for Humanity of Monongalia and Preston Counties, West Virginia.

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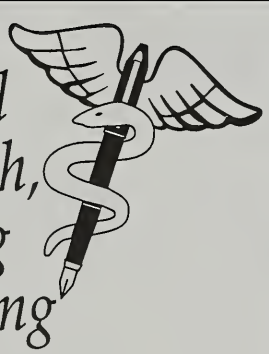

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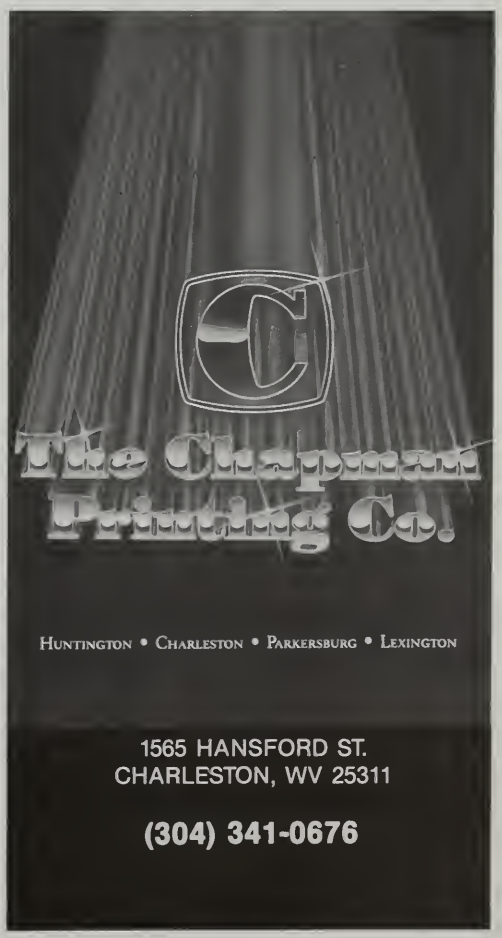

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West Virginia Medical JOURNAL

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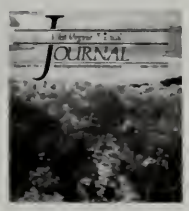


Front Cover

The trees on the hills near Mink Shoals outside of Charleston begin changing into their fall colors. Photo by *Nancy Hill*, managing editor of the *West Virginia Medical Journal*.

SPECIAL SECTION

Highlights of the West Virginia State Medical Association's 128th Annual Meeting

August 16-19, 1995

The Greenbrier
White Sulphur Springs, West Virginia

We wish to thank the participants of the WVSMA's 128th Annual Meeting.
Your commitment and support strengthens the WVSMA and is vital to its continued success.

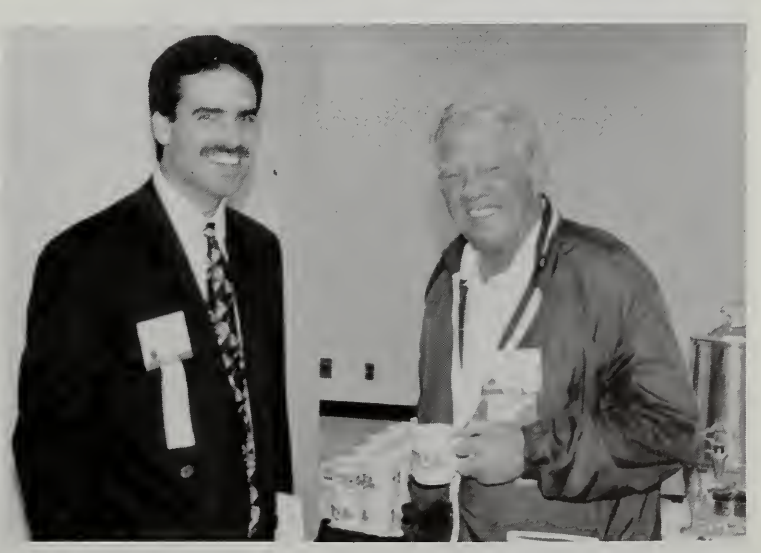
Legislator and WVSMA leader Dr. Robert Pulliam (left) was the proud recipient of this year's Wyeth-Ayerst Award for Community Service, which was presented to him by Mark Bowling of Wyeth-Ayerst.

The guest lecturer at this year's Surgery Section meeting was Dr. Robert Beart Jr., professor of surgery and chairman of the Division of Colon and Rectal Surgery at USC. Dr. Beart also presented the Thomas L. Harris Address and a lecture for the General Session.

Dr. William Morgan (left) is congratulated by Speaker of the House Dr. Harry Shannon after receiving a special plaque in honor of his years of service as treasurer of the WVSMA.

Former WVSMAA President Carole Scaring delivers her acceptance speech after she was awarded the 1995 Presidential Citation for her many contributions to health care, especially her efforts to stop cigarette smoking in West Virginia.

Dr. Ronald Cordell, president-elect of the WVSMA for 1995-96, discusses a resolution during the First Session of the House of Delegates.



A mentor to numerous med students over the years, Dr. Robert Hess enjoys visiting with David Faber, past president of the WVSMA Medical Student Section, during a break in the Exhibit Center.

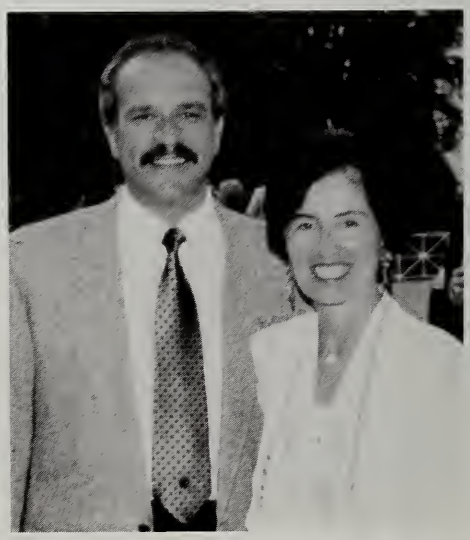
AMA President Dr. Lonnie Bristow addressed WVSMA members during the Second Session of the House of Delegates about *"The Practice of Medicine in the Changing Environment of Health Reform."*

At the reception hosted by Medical Assurance of West Virginia and Acordia of West Virginia, Don Sensabaugh, general counsel for the WVSMA, visits with Tamara Lively, Rob Vass and Bob Ludwig of Acordia.

Retiring Bluefield physician Dr. T. Keith Edwards and his wife, Alice, who is a past president of the WVSMA Alliance and an RN, were recognized by the members of the House of Delegates for their numerous contributions to the practice of medicine during their careers. Dr. Robert Pulliam described the Edwards as "a true portrait of a doctor's family."

WVSMA staff members Tim Allman and Sue Shanklin register participants for CME credit before the First Session of the House of Delegates.

Representing the Medical Student Section at this year's meeting were Dominic Cottrell, president; Melissa Matulis, vice president; Kristin DeHaven, secretary/treasurer; and David Faber, immediate past president.



Dr. James Comerci and his lovely wife, Lynn, were among the guests attending the reception hosted by Medical Assurance of West Virginia and Acordia of West Virginia.

This year's Publication Committee meeting was attended by Dr. Stephen Ward (fourth from the left), editor of the *West Virginia Medical Journal*, and Associate Editors Dr. Harvey Reisenweber, Dr. Mabel Stevenson, Dr. Robert Marshall, Dr. Joe Jarrett and Dr. John Hartman.

Dr. Thomas Chang was elected the new vice president of the WVSMA during the Second Session of the House of Delegates.

Gay Jackson (left) and Beth Hammers (third from left) of the Marshall University School of Medicine, were happy to have Linda Holmes, director of Alumni Affairs for Marshall, and Sherry Wallace, wife of Doug Wallace of SmithKline Beecham, with them at the reception sponsored by the WVU and MU Schools of Medicine.

Two of the popular Lunch and Learn events were conducted at this year's meeting. This first program featured Dr. Warren Point discussing *"Medical Ethics and the Rationing of Care"* with a panel of visiting dignitaries.

Dr. Generoso Duremdes and his wife, Dr. Janelle Duremdes make a striking couple at the reception hosted by the WVU and MU Schools of Medicine.

Team-mates Dr. James Comerci, his wife, Lynn, and Bruce Helsley, son of Dr. James Helsley, work to get the ball back over the net during the volleyball tournament.

With a powerful leap, Dr. James Helsley returns the volleyball over the net during the final game of the tournament.

Dr. Diane Paletta, wife of Dr. Reginald McClung, and her daughter, Kristen, were among the finalists in the tennis tournament.

Dr. Jeffrey Stead (left), chairman of the golf tournament, teamed up with Dr. John Hobart, president of the Pennsylvania Medical Society, Dr. William Morgan, and Dr. Richard Kerr for the tournament.

Terri Bailey (center) of Benchmark Data Systems visits with the representatives from Integrated Document Management at their booth in the Exhibit Center.

Legislator Jon Amores, his wife, Janet, and their youngest son, Marshall, prepare to sit down to enjoy the delicious buffet dinner which was prepared for the special outing at Kate's Mountain.

WVSMA Associate Executive Director Nancie Albright and Kathi Burton, wife of Dr. Dennis Burton, enjoy their chance to play the washboard with Cajun musician Waylon Thibodeaux and his band during their performance at Kate's Mountain.

Making quite a fashion statement in their hats were talented dancers Ruth Licata, wife of Dr. Antonio Licata, and her precious granddaughter, Victoria.

Getting into the act...Guests at the Kate's Mountain outing loved making music with the instruments which band member Elgin Thibodeaux (left), Waylon's father, brought out for them to play.

Dr. Dennis Burton and his wife, Kathi (center), were among the guests who danced the night away to the great Cajun music.

Showing some fancy footwork on the dance floor were Dr. Daniel Foster and his wife, Kathy.

Dr. Enrique Aguilar, a 50-year medical graduate, addresses guests at the luncheon honoring component/specialty society presidents, past presidents, visiting state presidents and 50-year grads. At Dr. Aguilar's left is Dr. Worthy McKinney, the other 50-year medical graduate who attended, and Dr. Dennis Burton, WVSMA president for 1994-95.

Retired WVSMA member Dr. Robert Crooks of Parkersburg presented a historical lecture on *"Health Problems of Our Presidents"* during the Second Session of the House of Delegates.

Sue Bryant, president of the WVSMA Alliance for 1994-95, shares a laugh with Sandra Mitchell, president-elect of the AMA Alliance, who was a special guest at the meeting.

Dr. Phillip Stevens of Huntington congratulates his uncle, Dr. Thomas Spelsberg of the Mayo Clinic, after he delivered a special slide show and lecture entitled *"Cosmic Adventure: Journey with Light."* Dr. Spelsberg also presented this year's Edmund B. Flink address.

Dr. James Helsley raises his hand and repeats the oath of office as Dr. Dennis Burton, president for 1994-95, swears him in as the new WVSMA president.

New WVSMA President Dr. James Helsley shakes hands with Dr. Dennis Burton after he presented him with the past president's pin.

Relaxing after his inaugural address, Dr. James Helsley enjoys joking with some of his colleagues from WVU, Dr. Karen Clark, Dr. Anne Cutlip and Dr. Rob Gerbo.

New WVSMA Alliance President Linda Elliott and her husband, Dr. Terry Elliott, were honored with new WVSMA President Dr. James Helsley and his wife, Vickie, at a reception sponsored by the Monongalia County Medical Society.

Clothing styles from various decades since the Alliance first began were highlighted at a fashion show which included models Linda Turner, Jeanny Kalaycioglu, Astri Jarrett, Debbie Lane, Pacita Salon, Ruth Gilbert, Subhra Datta, Sara Townsend, Judie Webb and Judy Bofill.

After being installed as the new president of the WVSMAA, Linda Elliott proudly has her president's pin placed on her lapel by her husband, Dr. Terry Elliott.

Astri Jarrett, WVSMAA Member of the Year, is congratulated by WVSMA Alliance Awards Chairman Alice Edwards.

At the Post Convention Board Meeting, new WVSMA President Dr. James Helsley visited with members and discussed projects for the coming year.

Alliance leaders Linda Curtis, WESPAC representative; Nancy Kessel, Legislative chairman; Carole Scaring, liaison for the Coalition for a Tobacco Free West Virginia; Arlene Clausell (at doorway), governing board representative from Monongalia County; and Jerry Crites, Northeast regional director; prepare to have lunch at the Post Convention Board Meeting.

1995 Resolutions

Resolution 1 (Adopted)

WHEREAS, most of the 8,000 West Virginians who start smoking each year are under the age of 18; and

WHEREAS, it is illegal to sell tobacco products to persons under age 18 in West Virginia; and

WHEREAS, the first organized compliance check in West Virginia determined that 14-16-year-olds could purchase tobacco products in 49% of their attempts; and

WHEREAS, West Virginia stands to lose about $800,000 in block grants this year from the Substance Abuse and Mental Health Services Administration if it cannot prove that it is enforcing the law prohibiting sale or distribution of tobacco products to minors; and

WHEREAS, 77% of West Virginia students surveyed in grades 9-12 had tried cigarettes, 39% had smoked during the last month, and 22% had used smokeless tobacco in the last month; and

WHEREAS, 70% of West Virginians polled in a 1994 statewide survey indicated that retailers should be required to have a license to sell tobacco products; and

WHEREAS, the WVSMA is a member of the WV Tobacco Control Coalition that is offering legislation to reduce availability of tobacco products to minors; therefore, be it

RESOLVED, that the WVSMA support legislation of the WV Tobacco Control Coalition that would require licensure of tobacco vendors, restrict youth access to cigarette vending machines, and other legislation that reduces availability of tobacco products to minors.

Resolution 2 (Adopted)

WHEREAS, municipalities and other forms of local government have adopted measures restricting tobacco purchase and use; and

WHEREAS, the tobacco industry is unable to prevent these measures on a local level; and

WHEREAS, the tobacco industry is offering legislation on a state level that would prempt local tobacco control measures from taking effect; therefore, be it

RESOLVED, that the WVSMA oppose legislative attempts by the tobacco industry to prohibit the authority of local government to adopt rules regulating tobacco use and purchase.

Resolution 3 (Adopted)

WHEREAS, an estimated 53,000 Americans will die this year from exposure to secondhand smoke; and

WHEREAS, secondhand smoke has been classified as a Class A cancer-causing substance by the U.S. Environmental Protection Agency, along with asbestos, radon, and benzene; and

WHEREAS, tobacco use in West Virginia causes over 4,000 deaths and costs the state over $546,000,000 annually in health care costs; and

WHEREAS, workplace smoking is associated with increased costs due to increased absenteeism, health care costs, fire insurance premiums, disability and premature mortality, workers' compensation, and property damage; and

WHEREAS, the Americans with Disabilities Act prohibits discrimination against individuals with disabilities, including conditions that affect the respiratory system; and

WHEREAS, workplace policies that limit smoking can protect workers from secondhand smoke; and

WHEREAS, 83% of West Virginians surveyed in 1991 supported laws limiting smoking in workplaces; therefore, be it

RESOLVED, that the WVSMA support legislation that would reduce exposure to secondhand smoke at worksites and public places.

Resolution 4 (Adopted - Expands Current WVSMA Policy 435.007)

WHEREAS, as the state and federal levels of government have proposed some type of tort reform; and

WHEREAS, the state of California is a model for tort reform that West Virginia could adopt; and

WHEREAS, the state of West Virginia has not enacted any tort reform in past years; and

WHEREAS, physicians need tort reform to reduce the cost of medical care; therefore, be it

RESOLVED, that the WVSMA support tort reform at the state and federal levels.

Resolution 5 (Adopted)

WHEREAS, 20% of the cost of medical care is in administrative cost; and

WHEREAS, insurance companies and third-party payors have different requirements for utilization review; and

WHEREAS, this does not contribute to the quality of patient care; therefore, be it

RESOLVED, that the WVSMA support a unified reporting system of utilization review for all third-party payors.

Resolution 6 (Not Adopted - Currently Covered by WVSMA Policy 505.002)

WHEREAS, West Virginia has a very high rate of tobacco use; and

WHEREAS, passive smoke inhalation has been shown to cause health problems; including smoking in public places; and

WHEREAS, tobacco use has been shown to be a major cause of health problems; therefore, be it

RESOLVED: that the WVSMA support an increase in tobacco tax on all forms of tobacco to .75¢ a pack to reduce the cost of Medicare and to ban smoking in public places and the proceeds of that tax would be used for the medical costs incurred due to tobacco use.

Annual Reports

Committee on Cancer

The members of the Committee on Cancer met for their 1995 annual meeting on Friday, August 18 at The Greenbrier.

After the minutes of the 1994 meeting were approved, Patricia Hilton, professional education coordinator for the Mary Babb Randolph Cancer Center's Breast and Cervical Cancer Screening Program, reported that there were posters available on self breast examination, brochures on cancer of the prostrate, as well as many other educational materials on cancer prevention. She announced that the center and the West Virginia Breast and Cervical Cancer Screening Program are offering a collection of videotapes which each provide one free hour of CME credit. Clinicians who would like to borrow videos may call the center's Cancer Education Department at 293-2370.

Ms. Hilton discussed the fact that a total of 10 programs have been transmitted in the past year over Mountaineer Doctor Television (MDTV), and the following 11 videos are or will soon be available:

— *Pap Smears: Why? When? How?* by R. Gerald Pretorius, M.D.

— *Abnormal Pap Management* by R. Gerald Pretorius, M.D.

— *Evaluation of Breast Lumps* by Richard Hostetter, M.D.

— *Estrogens and Anti-Estrogens* by Mark Gibson, M.D.

— *Diagnosis and Treatment of Breast Cancer* by Thomas Covey, M.D.

— *HPV and Early Cervical Cancer* by A. Patrick Soisson, M.D.

— *Women's Breast Health: The Role of Imaging* by Judith S. Schreiman, M.D.

— *Guidelines for Referral to Gynecologic Oncology* by R. Gerald Pretorius, M.D.

— *Estrogens, Progestins and Cancer Risk in Women* by Mark Gibson, M.D.

— *Multidisciplinary Breast Cancer Management* by R. Hostetter, M.D.; L. Korb, M.D.; and J. Lynch, M.D.

— *Treating the Nicotine Dependent Patient* by Elbert Glover, Ph.D.

In other business, Ms. Hilton announced that the West Virginia Breast and Cervical Cancer Screening Program is encouraging physicians to use the PDQ, the National Cancer Institute's comprehensive cancer information database. Information can be obtained by calling the Cancer Information Service at 1-800-4-CANCER, or through CancerFax, West Virginia CONSULT, or Physician's Online. She also stated that for further information about accessing PDQ, physicians may contact her at 293-2370. The committee members then asked that all of these activities promoted by the Mary Babb Randolph Cancer Center be published in the *WESGRAM.*

Nancye Bazzle, program director of the Cancer Control Program for the Bureau of Public Health, was the next speaker and she presented an update on the Breast and Cervical Cancer Screening Program. Ms. Bazzle stated Congress had re-authorized the program for another five years. She added that the states entering the 5th year of funding have not been advised as to whether the next grant application will be competitive or non-competitive continuation.

The Breast and Cervical Cancer Screening Program is included in President Clinton's proposed FY96 budget which combines CDC state-based prevention programs into three Performance Partnership Grants. The Chronic Disease and Disabilities Grant, which includes the program, has a FY96 budget request of $118 million and would be consolidated with the core components of chronic disease prevention programs, including the following surveillance systems:

— Behavioral Risk Factor Surveillance

— Cancer Registries

— Diabetes

— Disabilities

— Tobacco

Ms. Bazzle concluded her remarks by explaining the administrative cost savings that would result from implementing combined grants. CDC sets aside no more than 20% of its total budgeted amount for administrative costs. With a funding of $100 million, the Breast and Cervical Cancer Screening Program makes up the greater portion of this budget request.

An update on the West Virginia Cancer Registry was then given by Joyce Hunt. She reported that a preliminary report was published in the *West Virginia Medical Journal* in the May/June 1995 issue. She noted that from 1994 to August 15, 1995, the leading site of cancer in both sexes was the lung and bronchus with 1,101 reported cases. In males, the number of reported cases of prostate cancer was 722, and there were 243 cases of colon cancer, 122 cases of rectum and rectosigmoid cancer, and 665 cases of lung and bronchus cancer. In females, the number of breast cancer cases reported was 887, and there were 278 cases of colon cancer, 107 cases of rectum and rectosigmoid cancer, and 436 cases of lung and bronchus cancer. The committee recommended that the form used by physicians for reporting cases be published in the *WESGRAM.*

Dr. R. John Pearson discussed the Rural Appalachian Breast Cancer Center Program which has an emphasis on delivery of advanced breast cancer care to the rural settings and focuses on underserved patients. He will investigate this program in detail and give a report at a later date. The submission deadline for proposals to the Rural Breast Cancer Center Program is September 15, 1995.

Dr. Catalino Mendoza Jr., chairman of the Cancer Committee, announced that the Cancer Liaison Physician Program of the American College of Surgeons' Commission on Cancer has developed an excellent slide program entitled *"Smoking and Disease,"* which is geared toward the children in grades 6 through 9. During the ACS Cancer Liaison Meeting held at The Greenbrier on May 4, 1995, Drs. S. Willis Trammell, James Carey, Gereroso Duremdes, and Catalino Mendoza Jr., reported that they had presented this slide program with excellent responses.

Rick Vaglinete, M.D., discussed the value of pain control for intractible pain associated with cancer. He stated he

would like to present this issue at the Cancer Coalition Meeting scheduled for August 31, 1995, at the Days Inn in Flatwoods. He also commented on the dispensing of narcotics to cancer patients and the difficulty physicians are facing without proper documentation on patients who are terminally ill and bedridden.

Dr. Mendoza announced that the *Fall Cancer Conference: New Perspectives on Colorectal Cancer* will be held on November 3, 1995, at the Robert C. Byrd Health Sciences Center of WVU in Morgantown. The committee members recommended that the announcement about this meeting be published in the *WESGRAM.*

The meeting concluded after the committee's next meeting was scheduled for Friday, August 23, 1996.

Council

The fall meeting of the WVSMA Council was held on November 6, 1994, and the first item on the agenda was the submission and approval of the financial report. Dr. Morgan, chairman of the Finance Committee, then submitted the following recommendations for controlling costs:

1. Eliminating the policy of paying travel and lodging to committee members attending various WVSMA meetings.
2. Publishing the *WESGRAM* on a monthly basis rather than biweekly.
3. Discontinue producing the monthly copies of the *Medical Newsline.*
4. Reduce publication of the *Journal* to bimonthly.
5. Charge specialty sections an administrative fee for helping with organizing meetings.
6. Return the Mid-Winter Clinical Conference to Charleston on a permanent basis.

All of these items were unamiously passed by the Council, except the recommendation to publish the *Journal* on a bimonthly basis. The other actions taken at the meeting included the following:

• Dr. Comerci received the West Virginia Hospital Association's Distinguished Service Award in honor of his leadership on behalf of all health care providers in advocating meaningful change in the health care delivery system in West Virginia.

• A report on the WVSMA and WESPAC membership was given. The WESPAC total membership was 281 and total contributions for that period were $63,000. In addition, $24,950 was distributed in the primary election and $31,000 was distributed for use in the general campaign. These contributions were considerably higher than in 1993.

• Dr. Comerci reported on the results of the CME Accreditation Survey in July. The Committee for Review and Recognition approved four-years' recognition for the WVSMA as a result of this survey.

• Dr. Phil Stevens discussed the Citizens Against Lawsuit Abuse (CALA). This is an organization to help educate citizens of the need for tort reform. This program is well organized in the southern part of the state and is working to create chapters in the northern part of the state and the Eastern Panhandle.

The winter meeting of the WVSMA Council took place during the Mid-Winter Clinical Conference in Huntington on January 22, 1995, and the following items were addressed:

• The financial report was given and approved by the Council.

• The Executive Committee's recommendation to publish the *Journal* on a bimonthly basis was approved.

• An update was given on the Medicaid litigation by Don Sensabaugh. The court had decided on the issue of the 2% tax, saying the tax was constitutional. The lawsuit is still continuing with regard to the reduction of fees by 30% without going through the Medicaid Enhancement Board. At the time of this Council meeting, $98,800 had been spent on the litigation.

• An update was given on Medical Assurance of West Virginia, the WVSMA's new endorsed malpractice insurance carrier.

• A membership update was provided to the Council which indicated that the WVSMA's membership for 1995 was well ahead of the membership for this same period in 1994. The Alliance's report indicated that its membership was also coming in more quickly than it had in the prior year.

• An update was given on the Blue Cross/Blue Shield litigation by Don Sensabaugh and he indicated that little change had taken place concerning this litigation. The settlement is still some time away, however, and physicians will still be entitled to approximately 50 cents on the dollar when this litigation is finally settled.

The spring meeting of the WVSMA Council was held April 23, 1995. No actions were taken at the meeting because a quorum was not present. The issues that were discussed were as follows:

• The financial report indicated that, based upon the increased membership for 1995, funds available exceed funding of the prior year by approximately $80,000. In addition, expenses were slightly less than they were for the same period in 1994.

• Michele Grinberg of Flaherty, Sensabaugh, and Bonasso updated the Council on the status of the Medicaid Litigation indicating that the court had moved to a new scheduling order. She stated that discovery in this case is supposed to begin April through June.

• A report on membership indicated that as of April 23, 1995, the WVSMA had approximately 154 more members than at the same time last year.

• An update on the activities of the 1995 Legislature was given. The Medical Savings Account bill passed the Legislature, but the legislation proposed by the WVSMA was defeated.

• The report from the president of the WVSMA Alliance indicated that the Alliance members were preparing for their 70th convention and they were trying to involve a number of people who had previously not been active.

• Nancie Albright reported on the assessment fees implemented for annual reports received from organizations accredited for CME by the WVSMA. This fee will absorb expenses incurred in monitoring and accrediting the organizations and institutions for which WVSMA is responsible. To date, the amount of money received from these assessments was $7,500.

In other business at the spring meeting, the Council referred a number of proposed changes to the Constitution and ByLaws Committee. The Constitution change requested was to change the wording for a quorum for Council meetings from "40% of membership" to "40% of members of Council present." The changes proposed for the Bylaws were to:

1) Establish a standing committee for the Annual Meeting to develop continuity in program planning; and allow for the annual appointment of an honorary chairman.

2) Allow eligible persons who do not have an active component society to become members of the WVSMA.

3) Develop alternate councilor positions for better component society representation.

Before the meeting was concluded, the Council also approved donating $3,000 to the AMA for a litigation fund to promote passage of medical malpractice reform and product liability legislation.

Committee on Medical Education

The West Virginia State Medical Association (WVSMA) is recognized as a provider to accredit intrastate continuing medical education programs by authorization through the Accreditation Council for Continuing Medical Education (ACCME). WVSMA has maintained this role since 1972.

Interest has been expressed in accreditation for sponsorship of CME programs by the following: West Virginia Hospital Association, South Charleston; Stonewall Jackson Memorial Hospital, Weston; Wheeling Hospital, Wheeling; Behavioral Health Associates, Martinsburg; and Thomas Memorial Hospital, South Charleston. According to procedure, preliminary questionnaires and information on Essentials and Standards for Commercial Support have been sent to these organizations and hospitals interested in establishing CME accredited programs.

An initial application was received from the Bluefield Regional Hospital and the survey completed September 14, 1994. The survey team consisted of Warren Point, M.D., Nancie Albright, and Shirleen Lipscomb. A one-year provisional accreditation status was granted. A six-month interim report was required May 17, 1995, addressing suggestions for improvement. This report was received when due. Permission was also granted to implement joint sponsorship in six month's time.

Two six-month interim reports have been submitted and two organizations have been resurveyed since the last Annual Report.

Bluefield Regional Medical Center
Six-month interim report submitted

Broaddus Hospital
Six-month interim report submitted

Davis Memorial Hospital
Survey: March 16, 1995
Surveyors: James D. Helsley, M.D.; Nancie Albright; and Shirleen Lipscomb
Award: Two-year accreditation with six-month report due in October.

Broaddus Hospital
Survey: October 13, 1994
Surveyors: Frederick Spencer, M.D.; Nancie Albright; and Shirleen Lipscomb
Award: Two-year accreditation with six-month report due in April.

A preliminary resurvey has been received from Charleston Area Medical Center and is currently being acted upon.

Jackson General Hospital requested an extension on their resurvey due to personnel changes. An extension was granted until the end of July. Rick Mancini was contacted July 19, and he informed staff the accreditation forms would be mailed by August 1.

VA Medical Center, Martinsburg, requested a 90-day extension on their resurvey, and it is now scheduled for September.

WVSMA currently has 22 institutions/organizations accredited for Category 1 credit of the Physician's Recognition Award of the AMA:

American Heart Association WV Affiliate
Charleston, WV

Beckley Appalachian Regional Hospital
Beckley, WV

Bluefield Regional Medical Center
Bluefield, WV

Broaddus Hospital/Myers Clinic
Philippi, WV

Charleston Area Medical Center
Charleston, WV

City Hospital
Martinsburg, WV

Davis Memorial Hospital
Elkins, WV

Fairmont General Hospital
Fairmont, WV

Jackson General Hospital
Ripley, WV

Mid-Ohio Valley CME
Parkersburg, WV

Monongahela Valley Association of Health Centers (Fairmont Clinic)
Fairmont, WV

Pleasant Valley Hospital
Point Pleasant, WV

Raleigh County Medical Society CME Program
Beckley, WV

Reynolds Memorial Hospital
Glen Dale, WV

St. Francis Hospital
Charleston, WV

St. Mary's Hospital
Huntington, WV

United Hospital Center, Inc.
Clarksburg, WV

VA Medical Center
Martinsburg, WV

Weirton Medical Center
Weirton, WV

WV Academy of Ophthalmology
Charleston, WV

WV Academy of Otolaryngology
Charleston, WV

Wheeling Area CME Program
Wheeling, WV

The committee continues to monitor each organization in its compliance with the Essentials and Guidelines and the Standards for Commercial Support set by the WVSMA. The CME accreditation director attends all site visits with the survey teams as a source of continuity and uniformity in the application of standards for institutions/organizations.

Results of the Davis Memorial Hospital's resurvey and the 1994 Annual Reports were mailed to the Medical Education Committee for their review. A summary of these reports will be reviewed and approved or disapproved by the committee at the meeting scheduled August 17, 1995.

The Executive Committee and Council reviewed and unanimously approved the CME Mission Statement without change during their Executive meeting April 22, 1995.

Due to the recent illness of Chairman Dr. John Traubert, the CME-Workshop previously scheduled for May 18, 1995, was postponed as was the Medical Education Committee's first quarter meeting. Current plans are to reschedule the workshop in October or November, and a Medical Education Committee Meeting is scheduled for Thursday, August 17, 1995, during the Annual Meeting at The Greenbrier.

Ms. Albright and Ms. Lipscomb attended the 1994 ACCME Accreditation Workshop, August 12-13, 1994, in Williamsburg, Va. Ms. Albright attended the State Medical Society-ACCME Conference in Chicago, September 9-10, 1994, and is also scheduled to attend the same conference in Chicago, September 8-9, 1995.

Ms. Albright attended the 20th Annual Meeting of the Alliance for CME *"Managing Change in Health Care: New Responsibilities and Opportunities for CME,"* jointly sponsored by The George Washington University Medical Center and ACME, January 10-14, 1995, in Phoenix, Ariz.

Ms. Albright and Ms. Lipscomb attended the Ohio State Medical Association's 1995 Annual Symposium on CME as observers on March 21-22, 1995, in Columbus.

A request has been received from ACCME for the WVSMA Progress Report, due August 15, 1995. All recommendations made as a result of the 1994 re-recognition survey have been met and the report was mailed to ACCME on August 2, 1995.

Ms. Albright, CME accreditation director, will serve as a surveyor for the South Carolina Medical Association with Dr. Raphael Sanchez on behalf of the Committee for Review and Recognition of the ACCME on July 27, 1995. The resurvey will take place in Columbia, S.C. All expenses are paid by ACCME.

The ACCME is reconstituting its pool of volunteer accreditation site surveyors. A letter, application and brochure were received by Nancie Albright on April 18, 1995, asking her to submit an application which will be reviewed by the ACCME Quality Monitoring Committee by June 1, 1995. Eligible individuals will be invited to conduct site surveys and notified of training opportunities. James D. Helsley, M.D., and David N. Bailey, M.B.A., director of CME, Marshall University School of Medicine, submitted letters of recommendation on her behalf. The application was submitted in May.

Mark Your Calendar!

The 1996 West Virginia State Medical Association Annual Meeting is Coming Soon

August 25-27, 1996

Please be sure to make hotel reservations early by calling (800) 624-6070. Rooms at The Greenbrier will fill up quickly because the State Fair will take place during the same week.

For information about other hotels in the area, contact the WVSMA at (304) 925-0342.
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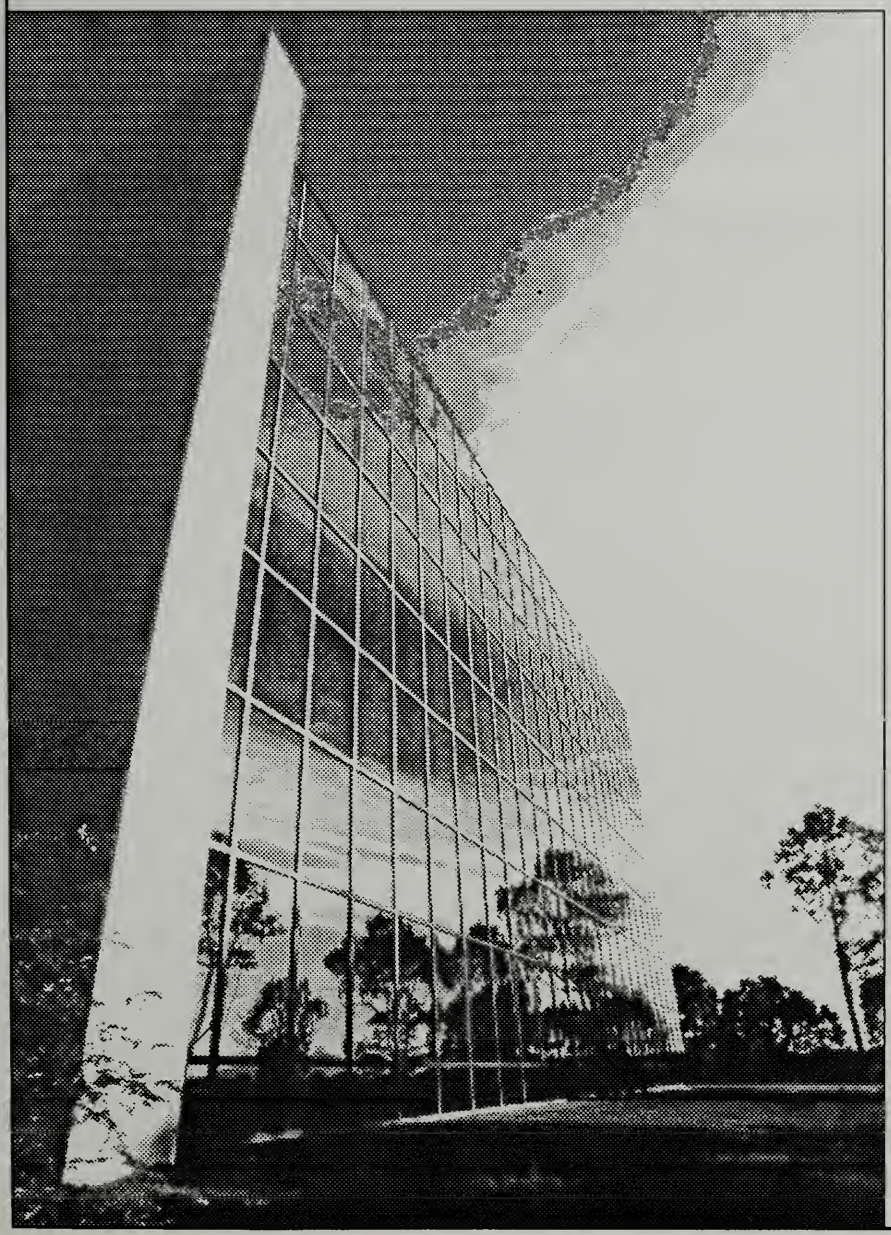

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A comparison of colon cancer cases at the Charleston Area Medical Center with the National Cancer Data Base Report

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Abstract

This article reviews the pattern of care and outcome of colon cancer cases seen at Charleston Area Medical Center (CAMC) between 1985 and 1991, and compares these statistics to the most current National Cancer Data Bank (NCDB) study. CAMC's statistics paralleled those of the NCDB study in several ways including the fact that both studies indicated that there appeared to be stability in the age and gender distribution of colon cancer between 1985 and 1991, and there was a continued trend of proximal migration of colon cancers. Both the CAMC and NCDB studies also indicated that AJCC staging was used increasingly as the standard of cancer diagnosis, and that multimodal therapy (e.g., chemotherapy) was increasingly available to patients at greatest risk for recurrence after surgery (stage III patients). However, the CAMC study indicated that compared to the NCDB, there was a greater incidence of colon cancer in females, and that a greater percentage of stage III patients received adjuvant therapy in 1990 (35.9% and 70% in the NCDB and CAMC studies respectively).

Introduction

Colon cancer is the most common cancer to occur in both men and women in the U.S. and it has the second highest probability of lethal outcome (1). In 1995, it is estimated that 100,000 cases of colon cancer will be diagnosed and that approximately 47,500 of these patients will die (1).

Recently, the American Cancer Society (ACS) and the American College of Surgeons' Commission on Cancer (COC) developed a vehicle for the annual assessment of trends in cancer care -- the National Cancer Data Base (NCDB). The major goals of the NCDB are to provide assessments of the care of patients with cancer and their outcomes on a national basis, and to disseminate this information directly to the medical community. The statistics from the NCDB include surveillance of trends in stage at diagnosis, prognostic indicators, therapy, and outcome (e.g. survival).

This article reviews trends in the pattern of care and outcome of colon cancer cases seen at Charleston Area Medical Center (CAMC) between 1985 and 1991, and compares this data to the most current NCDB statistics on colon cancer (2).

Methods

To create the NCDB, the COC issued two requests, first in 1990 and then in 1991, for colon cancer data to be submitted from cancer registrars throughout the U.S. in a standardized form (3). In response, registry data on patients diagnosed in 1985, 1988 and 1990 (including those at CAMC) was transmitted on diskette to the NCDB's Chicago offices (4,5).

The baseline data collected for this study included:

1) Patient characteristics (e.g. gender, age, race, etc.);
2) Tumor characteristics (e.g. primary site, histology, grade, number of positive lymph nodes, tumor size, clinical and pathological stage group per the American Joint Committee on Cancer's (AJCC's) Manual for Cancer Staging (Tables 1,2) (6);
3) The first course of treatment (e.g. surgery, chemotherapy, or radiotherapy);

TABLE 1. American Joint Committee on Cancer's TNM Staging of Colorectal Cancer (6).

Primary Tumor (T)

- T_x Primary tumor cannot be assessed
- T_0 No evidence of primary tumor
- T_1 Carcinoma in situ; intra epithelial or invasion of the lamina propria
- T_2 Tumor invades the muscularis propria
- T_3 Tumor invades through the muscularis propria into the subserosa or into non-peritonealized pericolic or perirectal tissues
- T_4 Tumor directly invades other organs or structures and/or perforates the visceral peritoneum

Regional Lymph Nodes (N)

- N_x Regional lymph nodes cannot be assessed
- N_0 No regional lymph node metastasis
- N_1 Metastasis in one to three pericolic or perirectal lymph nodes
- N_2 Metastasis in ≥ four pericolic or perirectal lymph nodes
- N_3 Metastasis in any lymph node along the course of a named vascular trunk and/or metastasis to apical nodes

Distant Metastasis (M)

- M_x Presence of distant metastasis cannot be assessed
- M_0 No distant metastasis
- M_1 Distant metastasis

TABLE 2. American Joint Committee on Cancer Staging (International Union Against Cancer)			
STAGE	T	N	M
0	Tis	N_0	M_0
I	T_1	N_0	M_0
	T_2	N_0	M_0
II	T_3	N_0	M_0
	T_4	N_0	M_0
III	any T	N_1	M_0
	any T	N_2	M_0
	any T	N_3	M_0
IV	any T	any N	M_1

TABLE 3. Percentages of Colon Cancer Cases by Sex and Year of Diagnosis						
GENDER	YEAR OF DIAGNOSIS					
	1985		1988		1990	
	NCDB	CAMC	NCDB	CAMC	NCDB	CAMC
Male	48.5	42.2	49.0	39.6	48.9	36.4
Female	51.5	57.8	51.0	60.4	51.1	63.6

TABLE 4. Percentages of Colon Cancer Cases by Patient Age and Year of Diagnosis						
AGE	YEAR OF DIAGNOSIS					
	1985		1988		1990	
	NCDB	CAMC	NCDB	CAMC	NCDB	CAMC
< 30	0.5	0.0	0.7	1.1	0.6	1.1
30-34	0.6	0.0	0.6	0.0	0.5	0.0
35-39	1.0	1.2	1.1	2.2	1.0	0.0
40-44	1.5	1.2	1.7	1.1	1.6	1.1
45-49	2.5	0.0	2.7	4.4	2.6	4.5
50-54	4.6	4.8	4.4	3.3	4.4	2.3
55-59	8.4	6.0	7.1	5.5	7.0	6.8
60-64	12.4	19.3	11.8	16.5	11.1	9.1
65-69	15.2	10.8	15.5	15.4	15.7	12.5
70-74	17.6	24.1	16.8	15.4	17.1	18.0
75-79	16.3	15.7	16.0	13.2	16.5	15.9
80-84	11.4	10.8	12.7	13.2	12.7	15.9
≥ 85	8.0	4.8	8.9	8.8	9.2	12.5
Median Age	69.1	69.5	69.5	68.7	69.9	71.1

4) Follow-up (e.g. last contact date, vital and tumor status); and
5) Hospital information (e.g. annual cancer caseload and type of hospital per the categories used by the COC approval program) (7).

Patients were classified as low income or moderate/high income based on the median family income of their zip code of residence (an annual income of less than $13,500 was considered low, an income equal to or greater than $13,500 was considered moderate/high).

Staging in the study was represented by the AJCC's staging system (the clinical AJCC stage group, where documented, augmented by the pathologic stage group, where the clinical stage group was missing) (6).

Results

As noted in Table 3, the data received indicated no significant changes in gender distribution for colon cancer between 1985 and 1990 both at CAMC and nationally (the NCDB study). There was also little difference in age distribution and average age at the diagnosis of colon cancer between 1985 and 1991 in the CAMC and NCDB data (Table 4). The CAMC data, though, indicated a slightly greater incidence of colon cancer in females than the NCDB data.

The trends toward proximal migration of colon cancers was reflected in the NCDB data from 1985 to 1991. This trend was much more striking at CAMC (Table 5), since almost 58% of colon cancers diagnosed at CAMC in 1985 were reported to be located in the sigmoid colon, compared to 44% in 1990. In addition, 6% and 19.4% of colon cancers diagnosed at CAMC were located in the transverse colon/hepatic and splenic flexures in 1985 and 1990, respectively.

As noted in Table 6, AJCC staging for colon cancer was used increasingly as the standard of appropriate cancer diagnosis. In the NCDB study, the proportion of colon cancer cases reported as stage "unknown" decreased from 42.5% in 1985 to 18% in 1990. In the CAMC study, the proportion of stage unknown cases decreased from 78% in 1985 to 6.8% in 1990.

There was no statistically significant difference in the reported state at presentation of colon cancer between CAMC and other hospitals (as noted in the NCDB report), or between the reported stage at presentation of colon cancer between CAMC and

other hospitals (as noted in the NCDB report) with a similar annual cancer caseload (i.e. > 1,000 cases/year) (Table 7). In addition, there was little difference in the CAMC and NCDB data from 1990 with respect to the distribution of colon cancer cases by AJCC stage and income level of non-hispanic whites (Table 8). Interpretation, however, may be compromised by the small sample size and the subsequent sample bias.

Treatment

By 1990, treatment trends were beginning to reflect the effects of clinical trial data (8), indicating the benefit of multimodality therapy for certain stages of colon cancer (e.g. adjuvant chemotherapy for stage III colon cancer) (Tables 9,10). For example, in 1985 only 9% of patients were reported to the NCDB as having surgery plus other therapy, whereas in 1990, this rate had increased to 20%. This trend was more evident at CAMC because in 1985, 7.2% of patients were reported to have had surgery plus other therapy, and in 1990 this figure had increased to 33%.

The data from both the NCDB and CAMC study show that patients were appropriately selected for multimodality therapy depending on their stage of disease. For example, 35.7% and 70% of stage III patients in 1990 received postsurgical adjuvant chemotherapy in the NCDB and CAMC studies respectively.

TABLE 5. Percentages of Colon Cancer Cases by Anatomic Subsite and Year of Diagnosis

SUBSITE	YEAR OF DIAGNOSIS					
	1985		1988		1990	
	NCDB	CAMC	NCDB	CAMC	NCDB	CAMC
Ascending Colon/Cecum	32.9	30.2	34.2	37.4	36.3	30.6
Transverse Colon/ Hepatic & Splenic Flexure	16.3	6.0	17.6	16.5	17.1	19.4
Descending Colon	8.7	6.0	7.6	3.3	7.7	5.7
Sigmoid Colon	35.4	57.8	34.7	41.8	33.7	44.3
Multiple Sites	0.9	0.0	1.9	0.0	1.1	0.0
Unknown	5.7	0.0	5.0	1.1	4.1	0.0

TABLE 6. Percentages of Colon Cancer Cases by AJCC Stage Group and Year of Diagnosis

STAGE	YEAR OF DIAGNOSIS					
	1985		1988		1990	
	NCDB	CAMC	NCDB	CAMC	NCDB	CAMC
0	5.0	2.4	6.2	3.3	6.2	5.7
I	15.7	3.6	20.3	16.5	18.3	15.9
II	14.6	8.4	21.3	31.9	24.3	30.7
III	13.0	6.0	17.9	29.7	19.3	22.7
IV	9.2	1.2	12.8	15.4	13.8	18.2
Unknown	42.5	78.3	21.5	3.3	18.0	6.8

Table 7. 1990 Percentages of Colon Cancer Cases by AJCC Stage Group

STAGE	CAMC*	Other (NCDB) hospitals with cancer caseload ≥ 1,000 annually
0	5.7	6.7
I	15.9	23.1
II	30.7	30.0
III	22.7	23.2
IV	18.2	17.0
CASES	88	7,030

* 6.8% of cases - stage unknown.

Survival trends

The 5-year relative survival rate was similar in both the NCDB and CAMC studies (Figures 1,2). The most obvious correlation was between stage and survival since the 5-year relative survival was 70% vs. 82% for patients with stage I disease, and 12% vs. 9% for those with stage IV disease in the NCDB and CAMC studies respectively.

The overall survival for colon cancer in the NCDB and CAMC studies was not different from that reported in other data bases.

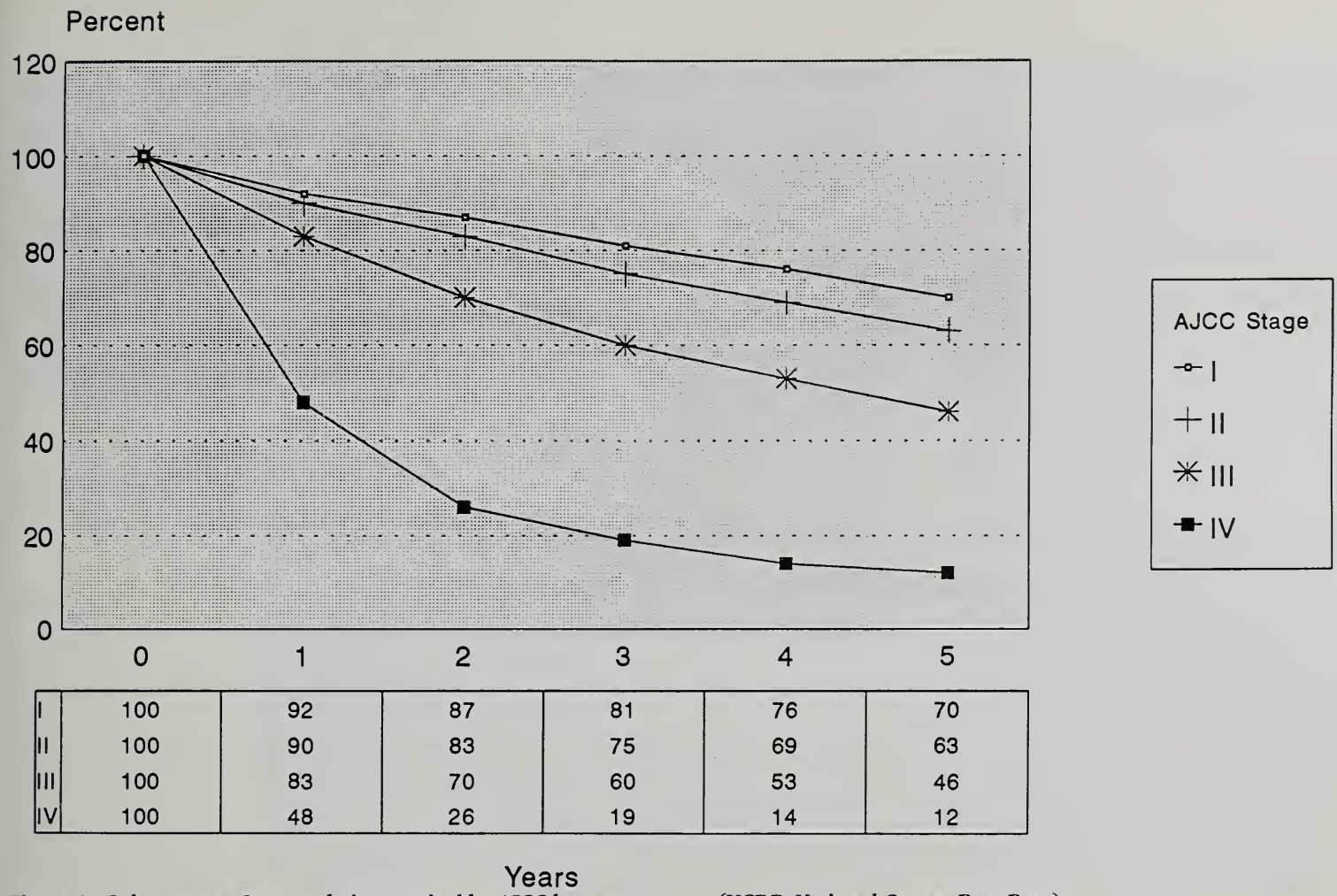
Discussion

Most of the results of the CAMC study on colon cancer between 1985 and 1990 parallel those of the NCDB by Steele and colleagues. In particular, both studies indicate that:

1. There appeared to be stability in the age and gender distribution of colon cancer;
2. There was a continued trend of proximal migration of colon cancers;
3. AJCC staging was used increasingly as the standard of cancer diagnosis; and
4. Multimodal therapy (e.g. chemotherapy) was increasingly available to patients who were at greatest risk for recurrence after resection of the primary tumor (particularly those with stage III disease). Due to the small African American and Hispanic patient population at CAMC, a comparison of data for these groups to those of the NCDB was not performed.

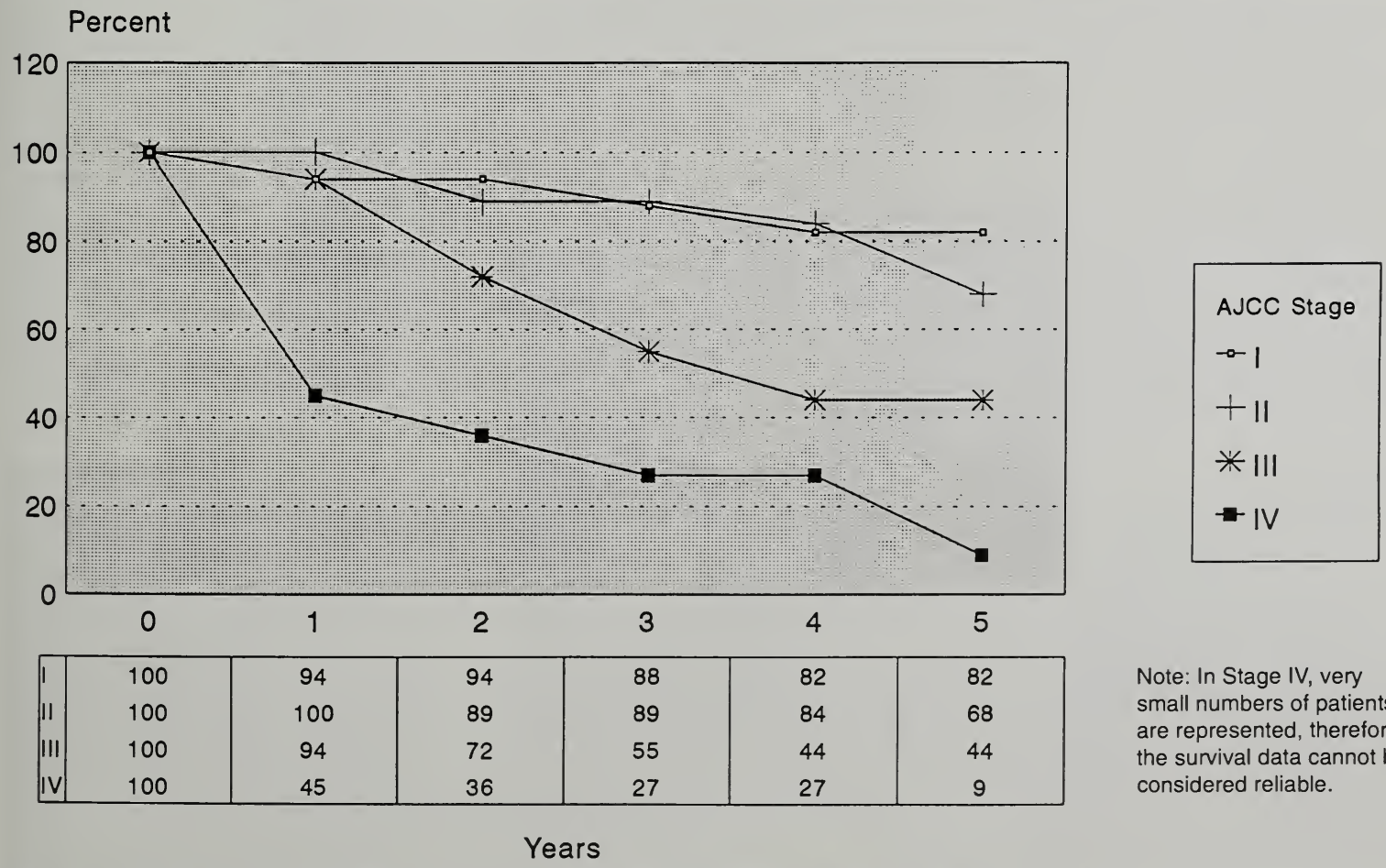
We noted, however, the following minor differences between CAMC's data and that reported to the NCDB:

1. The more striking trend at CAMC towards proximal migration of colon cancers; and
2. The greater use of adjuvant chemotherapy in patients with stage III disease at CAMC.



	0	1	2	3	4	5
I	100	92	87	81	76	70
II	100	90	83	75	69	63
III	100	83	70	60	53	46
IV	100	48	26	19	14	12

Figure 1. Colon cancer 5-year relative survival by AJCC best stage group (NCDB: National Cancer Data Base).



	0	1	2	3	4	5
I	100	94	94	88	82	82
II	100	100	89	89	84	68
III	100	94	72	55	44	44
IV	100	45	36	27	27	9

Note: In Stage IV, very small numbers of patients are represented, therefore the survival data cannot be considered reliable.

Figure 2. Colon cancer 5-year relative survival by AJCC best stage group (for Charleston Area Medical Center).

The annual contributions of data to the NCDB now represent 62% of all cancer cases diagnosed in the United States, making it the most broadly-based source of data on cancer patient care in the U.S. (10). As a result, hospital cancer committees, tumor registrars and the health care professionals actually caring for patients can assess the quality of cancer management and treatment standards using NCDB statistics. However, the ultimate beneficiaries are patients with prevalent cancers such as colon cancer who will gain access to state-of-the-art diagnosis and treatment.

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Table 8. Distribution of Colon Cancer Cases by AJCC Stage Group and Income (Non-Hispanic White), 1990

STAGE	LOW INCOME		MODERATE/HIGH INCOME	
	NCDB	CAMC	NCDB	CAMC
0	7.3	5.3	7.7	4.3
I	21.7	15.0	22.4	17.0
II	30.7	23.7	30.4	31.9
III	23.3	28.9	23.4	19.1
IV	17.0	15.8	16.1	19.1
Unknown	-	10.5	-	8.5

Table 9. Percentages of Colon and Cancer Cases by Treatment and Year of Diagnosis

TREATMENT	YEAR OF DIAGNOSIS					
	1985		1988		1990	
Surgery Only	83.1	79.5	77.4	82.4	73.5	59.1
Surgery/Chemotherapy	7.1	6.0	10.2	13.2	18.4	28.4
Surgery/Radiation/Chemotherapy	1.5	0.0	1.8	0.0	1.8	3.4
Chemotherapy	1.4	1.2	1.6	1.1	1.3	1.2
Other	4.3	6.0	3.1	2.2	2.2	3.4
None	2.6	7.2	5.9	1.1	2.8	4.5
Cases	10,329	83	16,387	91	26,821	88

Table 10. 1990 Percentages of Colon Cancer Cases by Treatment and AJCC Stage

TREATMENT	AJCC STAGE GROUP									
	0		I		II		III		IV	
	NCDB	CAMC	NCDB	CAMC	NCDB	CAMC	NCDB	CAMC	NCDB	CAMC
Surgery Only	91	100	91.8	100.0	82.3	74.1	57.1	20.0	48.7	56.3
Surgery/Chemotherapy	3.4	0.0	2.9	0.0	11.1	11.1	35.7	70.0	34.5	37.5
Surgery/Radiation/Chemotherapy	0.3	0.0	0.3	0.0	1.8	3.7	3.2	10.0	2.6	0.0
Chemotherapy	0.6	0.0	0.9	0.0	0.6	0.0	0.7	0.0	4.5	6.3
Other	1.2	0.0	0.9	0.0	2.5	11.1	1.8	0.0	3.9	0.0
None	3.5	0.0	3.2	0.0	1.7	0.0	1.5	0.0	5.8	0.0

Transvenous implantation of cardioverter defibrillators in the Electrophysiology Laboratory at CAMC

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Abstract

Since 1989, 78 patients have had Implantable Cardioverter Defibrillator (ICD) systems implanted in the Electrophysiology Laboratory (EPS) at the Charleston Area Medical Center. Between June 1993 and December 1994, 28 patients (21 males, 7 females) had new transvenous ICD systems successfully implanted in the Electrophysiology Laboratory. Coronary artery disease was present in 22 patients (76%). The mean left ventricular ejection fraction measured 28 percent (range 19%-45%), and the mean follow-up was 159 ± 112 days (5.3 months). Twelve patients (43%) experienced shock, with an average of three per patient. The implantation of transvenous ICD systems in an electrophysiology laboratory is feasible, efficacious, safe, and associated with rapid patient recovery. With advances in technology, the procedure is becoming more comparable to a pacemaker implantation.

Introduction

Ventricular fibrillation (VF) is the most common preterminal arrhythmia occurring in patients experiencing sudden cardiac death, and it usually evolves from ventricular tachycardia (VT). Current methods of preventing and treating these arrhythmias include the use of antiarrhythmic medications, endocardial resection, catheter ablation, and implantation of an implantable cardioverter defibrillator (ICD)(1-5).

The use of an ICD has gained widespread acceptability because of its effectiveness in aborting sudden cardiac death (5-8). In the past, implantation of this system required a thoracotomy, however, it is now more commonly implanted transvenously (9,10). This approach has significantly decreased mortality and morbidity, and has shortened the patient's hospital course (11). The use of biphasic shock devices has further simplified the procedure so much that a single endocardial electrode can be implanted in most patients without a subcutaneous patch electrode (12-14).

Due to improvements in technology, more electrophysiologists have begun to implant these ICD systems (15), and this article provides an insight into this process in an electrophysiology laboratory.

Patients

Since 1992, 60 patients have undergone ICD-related surgical procedures in the EPS Laboratory at the Charleston Area Medical Center. These procedures have included 30 ICD pulse generator changes, two ICD electrode implants and 28 new transvenous ICD systems implants.

Between June 1993 and December 1994, 28 patients (21 males, 7 females) with a mean age of 63 years had new transvenous ICD systems implanted. Coronary artery disease was present in 22 patients (78%), and idiopathic dilated cardiomyopathy was present in six patients (22%). The mean left ventricular ejection fraction measured was 28% (range 19%-45%). Cardiac arrest was the presenting symptom in 11 patients (39.3%); ventricular tachycardia was the presenting arrhythmia in 11 patients (39.3%); and 10 patients (35%) had syncope.

An electrophysiology study was conducted on 21 of the patients (75%) utilizing the EPS protocol previously reported (16). Sixteen patients (57%) had inducible VT, while VF was induced in two patients. Eighteen patients (64%) were taking antiarrhythmic medication before the device was implanted, and 12 patients had been taking amiodarone.

The ICD preimplant patient assessment included a psychology evaluation to detect any potentially adverse psychological responses to having an ICD. Patients having a previously-implanted ICD also visited prospective ICD candidates for emotional support.

Device implantation

All implant procedures were performed in the EPS Laboratory under general anesthesia. A tripolar pacing and defibrillation electrode was passed into the right ventricular apex via the left cephalic vein or occasionally the left subclavian vein. ENDOTAK

Figure 1. A pectoral implant in a 47-year-old man.

Figure 2. Chest radiograph of the patient in Figure 1. The ICD was placed just below the previously implanted permanent pacemaker.

Figure 3. A pectoral ICD implant in a 46-year-old woman.

lead models 0064 and 0074 were used in 25 patients and a Transvene lead was used in three patients.

Adequate pacing and sensing thresholds (1 < volt and R wave > 5 millivolts, respectively) were established using a pacing systems analyzer. Adequate defibrillation safety margins were then assessed using an external cardioverter defibrillator. A 100-volt or 10 Joules safety margin (i.e. the difference between the required energy to terminate VF and the maximum shock energy of the ICD system) was established in all patients.

The patients having a previously implanted permanent pacemaker were tested for pacemaker-ICD interaction. A pulse generator pocket was then made in the subcostal region after which the electrode was tunneled to the pocket. The pulse generator (Cadence in 22 patients, PCD in 5 patients, and Ventak P in one patient), was then connected to the lead and subsequently tested.

One patient had the ICD pulse generator implanted in the pectoral region above the pectoralis major muscle (Figures 1-2). A subcutaneous patch was used in six (21%) patients due to an elevated defibrillation threshold (DFT) using the transvenous electrode alone. Incisions were closed and the patients were transferred to the post anesthesia recovery area for approximately one hour.

Following recovery, they were transferred to a step-down telemetry floor. Pre-hospital discharge testing of the ICD system was performed in 15 patients (53%). The antitachycardia pacing feature of the ICD system was activated in nine (32%) of these patients.

Operative results

All 28 patients had a successful ICD implantation procedure in the EPS Laboratory. For those patients who required a subcutaneous patch, the mean duration of the procedure was 3.5 hours, and for those who did not require subcutaneous patches, the mean duration was 2.25 hours.

The average length of stay in the hospital after implantation of the device was four days (range 1 day - 7 days).

Complications

Postoperatively, two patients developed congestive heart failure and one required intubation. Both readily responded to diurectic therapy.

Another patient developed a moderate-sized ICD pocket hematoma which resolved spontaneously. In addition, one patient had a small pneumothorax which also resolved spontaneously, and one patient experienced a lead dislodgement which did not require repositioning because of maintenance of adequate sensing, pacing and defibrillation thresholds.

Antiarrhythmic drug therapy

Thirteen patients (46%) were discharged on antiarrhythmic medications after successful implantation, and four of these patients had never previously been prescribed an antiarrhythmic medication.

Nine patients (69%) were discharged on amiodarone and four patients (31%) were discharged on sotalol. These medications were used for the suppression of frequent VT, for slowing the rate of the VT, and for the prevention of atrial fibrillation.

Of the 18 patients on antiarrhythmic medications prior to ICD implant, seven had their medications stopped due to toxicity or inefficacy. In addition, we discontinued prescibing amiodarone for four of the nine patients (57%) who were taking this drug.

Follow-up

The patients were followed in the pacemaker clinic every three to four months. Devices were interrogated and the number of shocks assessed. Twelve patients (43%) experienced shocks with an average of three shocks occuring per patient.

With review of symptoms and ICD electrograms, nine patients (75%) had appropriate shocks, and three (25%) were experiencing inappropriate shocks. The underlying rhythms were sinus tachycardia (one patient) and atrial fibrillation (two patients).

Two patients had wound complications. The most significant complication was infection of the pocket in one patient (3%) which required removal of the entire ICD system.

Discussion

Since the market release of the ICD system in 1985, significant advances have occurred in technology related to implantation and function. While the early ICD systems required thoracotomy for implantation, most current ICD systems are implanted transvenously.

Recent reports have confirmed anticipated reductions in surgical morbidity, length of hospital stay, and hospital costs when the ICD system is implanted transvenously. These benefits

have occurred without a reduction in the efficacy of the device to abort sudden cardiac death. Thoractomy may still be used when a transvenous system cannot be implanted due to elevated defibrillation thresholds.

Past transvenous ICD lead systems have used from one to four different electrodes, but the recent systems now allow for the use of a single endocardial lead for most patients. This reduction of hardware has decreased the duration of the implant procedure as well as its technical difficulty, thus enabling the procedures to be moved from the surgical suite to the catherization laboratory where electrophysiologists have often become the implanting physicians.

In our study, all 28 patients had an ICD system implanted with few complications. All patients were able to walk on their first postoperative day and most could have been discharged home 48 hours after the procedure.

While this is an improvement compared with thoracotomy implantation, further refinements are needed. Tunneling of the transvenous electrode requires additional time and can cause inadvertent puncture of the epidermis or bleeding into the subcutaneous tissues. Current investigational systems utilize smaller pulse generators which allow for pectoral implantation of the entire ICD system.

We were able to implant the systems pectorally in two patients. One system was implanted anterior to the pectoralis major muscle since the patient had a large amount of superficial adipose tissue. The second patient (Figure 3) had the pulse generator implanted below the pectoralis major muscle. The pulse generators used were not the smaller investigational units. Satisfactory results may not be attainable with thin patients using these larger units.

Pulse generators capable of delivering biphasis shocks frequently do not need a subcutaneous patch electrode. A patch electrode was required in three patients (12%) who had a biphasic shock pulse generator implanted, while three of our patients (50%) having a monophasic shock pulse generator implanted required a patch electrode. The patch electrode placement also prolonged the implantation procedure. Patients requiring the patch had an average procedure duration of 3.5 hours vs. 2.25 hours for patients not requiring a patch.

During the follow-up period, 12 patients (43%) experienced at least one ICD shock which is comparable to the incidence in our previously reported group of 26 patients undergoing ICD implantation by thoracotomy (17). In this latter group, 11 patients (46 percent) experienced a shock over a 9.3 ± 5-month period.

The occurence of one or two shocks does not require immediate physician consultation, but it is indicated when symptoms such as syncope, chest pain or dyspnea accompany the shocks. An increase in the frequency of shocks and the occurence of shocks with specific body positions definitely warrants a physician evaluation. This should include interrogation of the pulse generator for documentation of the shocks, electrolyte assessment, review of medications, and assessment for other secondary causes of the arrhythmia such as myocardial infarction and congestive heart failure.

ICD shocks may be inappropriate due to malfunction of one of the ICD system electrodes. Chest and abdominal X-rays may be helpful in identifying this problem. Current ICD systems also store data which will assist in electrode evaluation.

In the past, patients with ICDs, were required to visit their physician every 2-3 months to reform the capacitors in the ICD generator. This was done by placing a magnet over the pulse generator or with a programmer. Newer generators do this automatically so patients just have to be seen every 4-6 months.

Participation in a patient support group should be emphasized to all ICD patients since depression, anxiety, and dependence are not unusual after ICD implantation. On the other hand, patients may also feel protected or enabled and need to share and express these emotions as well.

Conclusion

The implantation of transvenous ICD systems in the electrophysiology laboratory is feasible, effective, safe, and associated with rapid patient recovery. With further advances in technology, the procedure may become simpler and comparable to pacemaker implantation.

Presently, all transvenous ICD implants at CAMC are pectoral and utilize the smaller pulse generators, which were recently put on the market.

Acknowledgement

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Prospective comparison of laparoscopic and open cholecystectomy in a community hospital

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Abstract

Despite reports questioning its relative safety, laparoscopic cholecystectomy has gained rapid acceptance on the surgical scene in the past few years due to its perceived, but unproven advantages related to patient recovery and health care costs. This article describes a study conducted at the Charleston Area Medical Center in order to prospectively evaluate the comparative outcomes and expenses for 17 patients undergoing open cholecystectomies by a single surgeon using techniques of vigorous perioperative care, as well as 30 patients undergoing laparoscopic cholecystectomies by a single experienced laparoscopist. Results indicated that although patients undergoing laparoscopic cholecystectomy had a slightly shorter average length of hospitalization and used fewer postoperative analgesics, the average recovery time and hospital costs for the two procedures were similar.

Introduction

There has been an explosion in the use of technology for the general surgeon during the 1990s that has never been witnessed before. In particular, the exponential increase in the volume of laparoscopic cholecystectomies (now accounting for nearly 85% of all cholecystectomies) has been phenomenal, particularly in light of the fact that few data exist comparing the efficacy of the newer surgery to its more conventional counterpart.

This article describes a study conducted at the Charleston Area Medical Center (CAMC) in Charleston to prospectively compare laparoscopic cholecystectomy with newer techniques of conventional surgery. Almost all previous studies have been consecutive series with comparison to historical controls only (1,2). Of special note is a recent report by Barkun and colleagues which compared laparoscopic cholecystectomy and open "mini-cholecystectomy" in randomized fashion and concluded that laparoscopic cholecystectomy was associated with shorter hospital stays and faster recovery than open surgery (3).

Unfortunately, there have been many recent reports documenting significantly more catastrophic complications such as bowel perforation, vascular injury and extrahepatic biliary duct injury in laparoscopic cholecystectomy as compared to open cholecystectomy (4,5,6). Even though this situation has been noted particularly in the early experience of the surgeon, few would argue that even with the experienced surgeon, the incidence of these problems still exceeds that seen in conventional surgery (7,8).

In spite of this recognition, the general assumption has been that the perceived advantages of decreased hospitalization, recovery time, and cost for laparoscopic cholecystectomy more than make up for concerns about safety. Interestingly, in the last few years, conventional open cholecystectomy performed on an outpatient basis has been reported by multiple surgeons (9,10,11). The initial report by Ledet in 1990 emphasized vigorous perioperative care far exceeding that noted in the "mini-cholecystectomies" reported by Barkun, and it was striking in its claims of postoperative morbidity and recovery similar to that reported for laparoscopic cholecystectomy.

Until now, there has been no prospective comparison of the ambulatory cholecystectomy techniques of Ledet to those of laparoscopic cholecystectomy. This study was an effort to compare these approaches in a controlled setting to see if the recovery and cost advantages truly exist for laparoscopic cholecystectomy.

Methods

Due to the intense marketing of the perceived benefits of laparoscopic techniques, we found it exceedingly difficult to set up the ideal randomized prospective trial to compare these ambulatory cholecystectomy techniques to those of laparoscopic cholecystecomy. Although this was done in the study by Barkun and colleagues (presumably because of special circumstances), most patients are already certain of which procedure they want when they first see the surgeon, thus precluding consent to randomization.

As a result, it was elected to carry out two consecutive and concurrent series of patients operated on at CAMC in Charleston over an eight-month period (1/1/92 to 8/31/92). Included were 30 laparoscopic cholecystectomies and 17 open cholecystectomies.

The laparoscopic surgery group consisted of seven males and 23 females with an average age of 52.2 years (age range 27 to 78). The open cholecystectomy group consisted of one male and 16 females with an average age of 45.0 years (age range 21 to 79). Otherwise, the groups were similar in all basic characteristics, including weight and comorbidities.

The laparoscopic cholecystectomies were performed by the most experienced laparoscopist at CAMC in the usual fashion, while the open cholecystectomies were performed by a single surgeon with the most experience in the technique popularized by Ledet. The special modifications to the traditional cholecystectomy were:

1. The fascial layers prior to closure were infiltrated with a solution of 0.125 percent bupivacaine hydrochloride with epinephrine. The rectus abdominis muscle was infiltrated with a solution of 30 mg of dexamethasone diluted in 40 cc of 0.125% bupivacaine in epinephrine.
2. Oral analgesics and antiemetics were given around the clock for the first 24 to 36 hours rather than when requested by the patient. Typically, one to two Tylox capsules were given every two hours and 12.5 mg of Phenergan was given every four hours. Doses were not given if the patient appeared excessively drowsy. (Recently, it was discovered that Mepergan Fortis, a combination of Demerol and Phenergan, given every two hours for 24 to 36 hours works quite well).

3. An abdominal binder was used routinely for one to three weeks, and was initially applied in the recovery room.
4. Patients were ambulated and fed early, usually within four to five hours

The patients were entered into both series prospectively with a full understanding of the purpose of the study. Data from the hospital charts included complications, length of surgery, and length of hospitalization. Hospital bills were obtained to ascertain direct hospital costs.

A nurse reviewer acceptable to both surgeons contacted all patients seven days after surgery to obtain subjective information regarding their postoperative period. Information requested included type and amount of analgesics used, the approximate time to recovery of full function, and when they planned to return to work.

Results

There were no readmissions or significant complications in either group, but one patient in the laparoscopic group was converted to open surgery.

The average operating time was 52.6 minutes for laparoscopic patients and 65.6 minutes for open surgery ($p < .001$). The length of postoperative hospitalization averaged 12.8 hours for the laparoscopic patients and 22 hours for those having open surgery ($p < .001$). The differences in the use of analgesics are noted in Table 1.

TABLE 1. Use of Analgesics

LAPAROSCOPIC	Tylenol/Advil/Tylenol #3 for 1-2 days
CONVENTIONAL	Tylox for 1-2 days, then Darvocet N-100 for 1-2 days

Of the patients undergoing open cholecystectomy, 71% (12 of 17) claimed to have returned to their normal activities at seven days postoperatively with the average time of those responding being 5.21 days. Of the laparoscopic patients, 90% (27 of 30) claimed to have returned to their normal activity in seven days, which resulted in an average time of 5.22 days. In addition, the patients who did not feel that they had returned to normal activity all gave a date when they planned to return to work. Assuming that returning to work is resumption of normal activity for these patients, then the average return to normal for laparoscopic patients was 6.1 days and for open patients was 7.2 days ($p = .32$ which was not statistically significant).

One of the most notable anecdotal findings of this data was the fact that the patient claiming the earliest return to normal activity was a patient who had undergone open cholecystectomy. Additionally, one of the patients classified in the laparoscopic group with the least morbidity was the single patient who was converted from laparoscopic to open surgery.

Average hospital costs in these two series were $4,255 for the laparoscopic patients and $4,062 for the open patients ($p = .23$ which was not statistically significant).

Discussion and conclusions

It has been a credo in the surgical and medical community that, in uncomplicated cases, laparoscopic cholecystectomy is far less morbid and expensive than any technique of open cholecystectomy. However, other than the single study from McGill, there has been no prospective, controlled evaluation indicating that this advantage exists.

The CAMC study goes one step beyond Barkun's report in prospectively comparing the newer techniques of open cholecystectomy reported by Ledet with laparoscopic cholecystectomy. The results indicate that when open cholecystectomy is performed in this fashion that:

1. Although patients may spend a little more time in the hospital during the initial stages of implementation of this procedure and use more analgesics, their return to normal function is no longer than with laparoscopic cholecystectomy.
2. Hospital costs for laparoscopic cholecystectomy, rather than being less than for open cholecystectomy, as expected, were in fact a little higher in the context of this study (though not statistically different), even though open cholecystectomy patients had a slightly longer average length of hospital stay. With the expected evolution of the same day approach of Ledet for the vast majority of open cholecystectomies, the average cost savings for open cholecystectomies performed in this fashion would likely be in the range of $800 to $1,000 per procedure. This cost differential relates primarily to the lack of need for specialized equipment.

As Dr. Leonard Schultz, a laparoscopic proponent, has pointed out, "It may yet come to pass that laparoscopy may prove to be nothing more than the stimulus needed to realize the full value of currently available conventional surgery" (12). Along this line of thinking, I feel that perhaps we should be refining our technique of perioperative care rather than inventing new laparoscopic paraphernalia.

There are many lessons to be learned from the experience of the last few years - - especially the fact that proper randomized prospective trials must be used to document the true benefits of any perceived advance in treatment. Moreover, the trials should evaluate comparable procedures in comparable patients.

We must also be wary of any Madison Avenue approach to presenting new treatments in the lay press, for it has been said that laparoscopic general surgery was not originally recommended in the *British Journal of Surgery* or in the *New England Journal of Medicine*, but in the *Wall Street Journal*. For example, many belive that laparoscopic cholecystectomy is "laser surgery" or perhaps not a real operation at all. Interestingly, there has been no serious attempt to correct these misconceptions, and many physicians now realize that patients have not been adequately informed of the procedure's risks.

As alluded to earlier, there are many financial incentives inherent to this evolving scenario over the last three to four years. The groups who are financially benefiting from this new procedures are:

1. Surgeons who may be reimbursed more for the new procedures (some of whom have invested in companies making laparoscopic equipment);
2. Hospitals that may profit from the increased operating room charges;

3. Both hospitals and surgeons who fear loss of market share if they do not offer the technology;
4. Gastroenterologists whose services are now much more in demand because of the technical inadequacies of laparoscopic cholecystectomy; and
5. The medical device manufacturers who have made hundreds of millions of dollars and stand to profit much more as they try to push this emerging technology beyond the limits of good judgment (both medical and economic).

Another important aspect of this discussion is a recent report in *JAMA* that the incidence of the performance of cholecystectomy, which had been stable for years, has rapidly risen 30% - 50% over the last three years (13). It is hard to believe that for years, too few cholecystectomies were being performed, but rather it is more likely that many patients with minimal or no symptoms are now having cholecystectomies because of the recent widespread publicity about laparoscopic techniques. As a direct result, there has been a significant increase in the total amount spent nationally for treatment of gallbladder disease.

With today's concerns about health care reform and escalating health care costs, it appears that Ledet's novel approach to conventional cholecystectomy offers significant cost savings as well as similar recovery benefits to those reported with uncomplicated laparoscopic cholecystectomy. In addition, it is critical to also consider the increased incidence of catastrophic technical complications noted in laparoscopic cholecystectomy (reportedly 5-10 times that seen in conventional surgery for vascular, bowel and bile duct injuries) (14) and the significant capital expense for equipment and ancillary assistance.

In conclusion, we may be ignoring a procedure which is arguably safer, cheaper, and with comparable recovery times. At the very least, further intense investigation is necessary to clarify these issues. It is obvious that many of the previous assumptions regarding cost and recovery are untenable.

No procedure should be considered the standard of care simply because the public thinks they want it and because surgeons are reimbursed more for it by insurance companies. Rigorous scientific studies must be conducted to show whether the benefits of laparoscopic cholecystectomy truly outweigh the risks when compared to conventional therapy. As Yogi Berra once said, "It's not what you don't know that gets you into trouble. It's what you know for sure that just ain't so."

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The effect of granulocyte colony stimulating factor in patients with leukopenia due to sepsis

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Abstract

The use of granulocyte stimulating factor (G-CSF) (Neupogen, Amgen Inc., Thousand Oaks, Calif.) has become acceptable for treating both primary and acquired leukopenia. Leukopenia associated with infection is an ominous sign of overwhelming sepsis. In this article, we present two cases of infection that were related to leukopenia which were successfully treated with G-CSF.

Introduction

Leukopenia related to infection is an ominous sign of overwhelming sepsis. Until recently, the only treatment available for this condition was antimicrobial therapy, but this therapy fails to address hematopoietic failure in patients. The advent of recombinant DNA technology, though, has brought several growth factors to aid in the support of hematopoiesis - - granulocyte colony stimulating factor (G-CSF) and granulocyte macrophage colony stimulating factor (GM-CSF).

G-CSF has been studied extensively in patients with primary and acquired leukopenia and has been found to be effective in increasing both the number and functionality of white blood cells (1,2). The majority of data regarding acquired leukopenia involves patients with cancer who were treated with chemotherapy and its resultant bone marrow suppression (3,4). However, there have been documented cases of improvement of infection related to leukopenia among high-risk patients (alcoholics with pneumococcal infections) using G-CSF (4,5).

This article describes two patients without predisposing risk factors who became leukopenic due to infection and were successfully treated with G-CSF.

First case report

A 74-year-old white male was brought to the Emergency Department at Ruby Memorial Hospital in Morgantown with signs and symptoms consistent with complicated diverticulitis and a white blood cell count of 1,800 cells/mm3 (85% neutrophils, 7% lymphocytes, 7% bands, 1% monocytes). He was found to have a perforated jejunal diverticulum with generalized peritonitis, so a primary resection of the perforated bowel segment was performed with primary anastomosis.

Postoperatively, this patient's white blood cell count dropped to 1,200 cells/mm3 (55% neutrophils, 11% lymphocytes, 10% monocytes, 3% metamyelocytes and 21% bands), so he was started on 300 micrograms of G-CSF in addition to the broad spectrum antimicrobial coverage which he had already been prescribed. Within 24 hours, when the white cell count increased to 4,900 cells/mm3 (63% neutrophils, 8% lymphocytes, 2% monocytes, 2% metamyelocytes, and 25% bands). By the third day of treatment, his white cell count had increased up to 7,900 cells/mm3, so the G-CSF was discontinued. The patient continue to improve and was eventually discharged from the intensive care unit and the hospital.

Second case report

A 66-year-old white female, who was a patient in the ICU at Ruby Memorial Hospital after undergoing an pancreaticoduodenectomy for peri ampullary carcinoma, was discovered to have infected ascites. She had not received chemotherapy or any othermmune suppressive therapy.

When the pancreaticoduodenectomy was performed, surgeons found a hepatic abscess with necrosis which was resected. Before surgery, her white blood cell count at admission was 9,100 cells/mm3 (84% neutrophils, 5% lymphocytes, 9% monocytes, and 2% bands), and after surgery, her white cell count dropped to 2,200 cells/mm3 (88% neutrophils, 9% lymphocytes, and 3% monocytes). A dose of 300 micrograms of G-CSF was then given intravenously, in addition to the broad spectrum antimicrobial therapy she was already following.

After 48 hours, the white cell count had increased to 5,500 cells/mm3 (85% neutrophils, 8% lymphocytes, 5% monocytes and 2% bands), so the G-CSF was discontinued. This patient did improve clinically, but subsequently was moved back to ICU when she developed a secondary abscess of the spleen.

Discussion

Leukopenia has long been recognized as a risk factor for increased mortality from infection (6). Despite advances in the use of antimicrobial drugs, the overall mortality related to infection continues to be high (5), which may be related to host defense capability.

The enhancement of hematopoietic function may play an increasing role in the treatment of infection as more data is acquired regarding G-CSF. In clinical studies in patients with both primary and secondary myelosuppression, G-CSF administration has resulted in reducing the number of days of antibiotic administration, hospital stay and the number of documented infections (3-5).

The improvement of both number and functionality of white cells has also been documented (1). G-CSF is certainly well tolerated, and mild to moderate bone pain is the most frequently reported adverse side effect (4).

Further controlled studies are needed to fully evaluate the utility of G-CSF in the septic leukopenic population.

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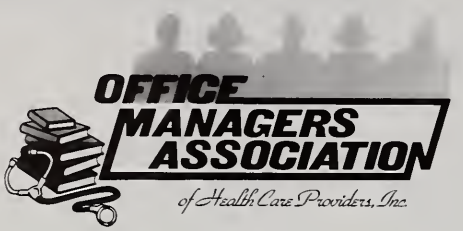

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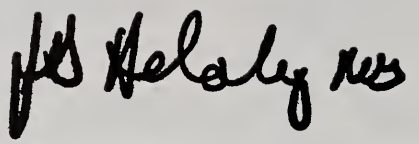


The only constant is change

Editor's Note: The following is Dr. Helsley's inaugural address which he delivered on August 19 during the WVSMA's Annual Meeting.

Dr. Burton, Mr. Speaker, members of the Executive Committee, delegates, family, friends and guests. Thank you for such a warm reception. Few physicians are afforded the opportunity to lead this association, therefore I stand before you today with a sense of gratitude, humility and honor. The responsibilities of leading this association unite to form a challenge; a challenge that, today, I accept.

At the time I was handed my medical degree in a graduation ceremony at WVU in May 1977, life, to me, appeared relatively simple. I was high. I was excited. All of the struggle and sacrifice in my career to that point paled in comparison to the satisfaction of being called "DOCTOR." As my career as a physician was beginning to take shape in the late 70s, I looked to the future and made some estimates as to what influences would impact on my career.

One of my predictions was that by the year 2000 or so, government would attempt to control the practice of medicine. Fee regulation, limited therapeutic and diagnostic options and the outright socialization of health care, were all concepts that I felt society might BEGIN to discuss by the year 2000. But it was the late 70s and all of this intrusion into sanctity of the practice of medicine was a futuristic nightmare that I felt would never come true. Boy, was I wrong!

Many have tried to foretell the future. Frankly, I'm growing tired of the pundits with their hoopla, forecasts and predictions of winners and losers in the health care arena. When there are so many "experts" predicting the future, the only valid conclusion is that none of them know what they are talking about in the first place. I'm not that old, but I've experienced enough of life to realize that things never quite turn out as predicted. The only thing that never changes is change itself.

The first 15 years of my career in practice have passed. In 1980, when I started my solo family practice in my hometown of Berkeley Springs, I had no idea how many changes I would go through. Life, in general, is a roller coaster that is frightening enough, but combined with the practice of medicine, life becomes a never ending set of emotional course changes. With each new experience comes new knowledge and having experienced the likes of SB576, liability insurance company abandonment, bankruptcy of Blue Cross/Blue Shield, the Medicaid tax, the National Practitioners Data Bank, and the Hillary Clinton health care reform fiasco, I'm certainly becoming full of experience and knowledge; actually a lot more than I bargained for.

When I look back at these and other crises, I wonder how any of us survived and I'm amazed. When the smoke cleared after each of these disasters in the House of Medicine, I looked around and saw you, my colleagues, there in the aftermath with me. Despite all the changes, despite all the nightmares, despite all the turbulent times, we still come together in this organization to pick up the pieces and make a plan for the future. This organization

During his inaugural address, Dr. James Helsley emphasizes a point about "disasters in the House of Medicine" which have occurred during the past few years.

is a long way from being perfect, and it may not be everything for all people, but the WVSMA is way ahead of whatever might be in second place.

I chose to pursue a career as a physician for several reasons, but a strong force was a desire to become a professional. The practice of medicine is an art and a science, yet above all, it is a profession. I'm proud of what I do. Society grants to physicians rights and privileges that are not offered to any other group. The commitment and responsibility that accompany being a doctor is balanced by the satisfaction and deep personal reward that come from being known in the community as a professional; a healer; a doctor. No managed care organization, insurance company, HMO, trial lawyer or politician can ever take away all that comes with being called "DOCTOR."

In an effort to control and manipulate the medical profession, outside forces have invaded an area which we hold sacred. The profession has been tarnished by those who hold the almighty dollar as the guiding light of truth. I like money as much as the next guy; but, I took an oath to be a physician; a professional. In this age of skepticism, it may seem out of place to assert a do-gooder philosophy. Now, it's true I'm, by no means, a saint; yet, I am proud to admit my adoration for and sacrifice in being a doctor. I don't hide the fact that I'm a doctor. This association is a collection of doctors; professionals, who feel in different words and different thoughts, much the same way.

The oft-used phrase of "United We Stand-Divided We Fall" is more poignant now than ever. This association of physicians represents what is good about being a doctor. There should be no shame by announcing to society who we are, what we do, and what we stand for. If not us, WHO?

West Virginia doctors are here because we want to be, not because we have to be. There are 49 other states that issue a license to practice medicine, but we live HERE. This is our backyard - - our turf - - and it's turf worth fighting for. To passively yield would be an insult to the ideals of the profession. We've sacrificed much to become doctors. To those who come after us, we have a duty to maintain the values and strengths of the practice of medicine that were given to us. To do otherwise would be a horrible disservice to the profession.

Today, I begin my term of office as your president. I have never and will never regard this association as my own. I don't plan to rule the organization this coming year; rather, I intend to stand watch over it. This association belongs to its members, you here today and those doctors around the state who work hard at their profession day in and day out. For you, the members, I intend to represent the WVSMA to the best my talents will allow.

I now look forward to beginning my duty on watch.

James D. Helsley, M.D.

At the reception honoring the newly-installed officers of the WVSMA and WVSMAA, WVSMA President Dr. James Helsley proudly poses with his wife, Vickie; their sons, Bruce and Benjamin; Vickie's parent's Robert and Mary Lou Marrara (left); and his parents, S.D. and Jean Helsley (right.)

Medical care compliance

Medicine continues to make good political fare. We now witness the Medical Establishment along with the Republican party being vilified for either holding onto the golden goose of Medicare or attempting to wring the neck of that molted, starving, sad-looking bird.

There are still some about who can recall the days of the AMA's fierce resistance to the King Anderson bill (Medicare's predecessor) in the early 1960s. We were doing pretty well at that fight, too, until a bit of Johnson administration legerdemain produced Medicare. Medicine swallowed hard and accepted the law of the land. Our argument in opposition to government controlled medicine was that it was going to be too expensive and we could not afford it.

No one can claim that Medicine failed to make every effort to make Medicare work. We just made it work too well. That, it quickly became apparent, was not exactly what Congress wanted. It would have been nice if we had left many of their promises unfulfilled or only partially fulfilled. But, no, we had to ruin everything by taking Congress at its word. We gave those covered under its terms everything the politicians promised them. In those halcyon days before anyone began adding up the cash register tape, the more pleased the recipients seemed the more was promised. More and more disability and advocacy groups were festooned to the list of those covered.

Medicare in those days was *free*. No one receiving its benefits had paid into it anything near the cost of even one day's benefits. At what point someone began talking about medical care as a *right* is difficult to say. It is quite clear, however, that up until that time medical care was not a right. The idea was an immediate hit, however, and a very popular political concept. If it's a right and free to boot, let's have more of it! Demand had been unleashed. It became a heavy truck careening down a narrow mountain road. Now, politicians have the unhappy task of putting on the brakes.

Medicare recipients cannot be faulted. They acted very predictably and very normally and still do. Medicare beneficiaries have, moreover, adjusted their plans, lifestyles and spending habits in accord with what has been promised and assured them. To expect them to be anything but enraged at threats they perceive to their security is unreasonable.

We hear now of planned attempts to induce present Medicare beneficiaries to accept managed care medicine. Good luck with these efforts, but these people have been spoiled by their exposure to traditional medicine with *their* doctor. They are unlikely to be taken in by promises of care that no managed care plan has any intention of ever fulfilling. Those poor souls who are taken in by HMO drummers are likely to be dreadfully unhappy with not just the medical care, but with the government which led them to choose that form of care.

It seems very clear that several options for future medical care will have to be offered to those presently covered and those shortly to be covered by Medicare if the program is to survive in any way. It is also quite clear that doctors in the future, as in the past, will obey the laws of the land and will do all in their power to provide all of the medical care all of their patients need and deserve -- to the extent allowed by law, that is.

Stephen D. Ward, M.D.
Editor

Seriously past due accounts lose collectable value

Time may improve wine but it does nothing to improve the quality of bad debts. Delinquent accounts are more like milk because they have a limited shelf life. The longer an account has been past due, the less likely it can be collected. That's why I.C. System, the nationwide accounts receivable management company the WVSMA endorses, recommends that debts be submitted for collection as early as possible.

Naturally, your practice will attempt to collect debts before turning them over to an agency. This is prudent business practice. Also, n many cases you want to work with the patient who is having financial problems by setting up a comfortable payment program. But, when the patient fails to keep his/her payment promises or simply makes no attempt at all to pay, the process can get out of hand. The results are debts that are seriously past due and difficult to collect.

To avoid this problem, I.C. System suggests that your office follow this five-step process:

1. **Day One-First Billing:** Present your bill when you provide your service, or mail the bill immediately thereafter. Do your billing more than once a month.
2. **30 Days Later:** Send a second statement.
3. **60 Days Later:** Make your first telephone call to the patient, inquiring why the bill hasn't been paid. Be prepared to clarify the amount of the bill, its due dates and the services rendered. Although you should ask for payment in full, it may be necessary to negotiate an installment payment plan. Make specific arrangements about when you are to receive payments and have the person responsible for paying the bill repeat this agreement back to you.
4. **60-to-90 Days Past Due:** Make follow-up telephone calls if the patient fails to make payments according to the arrangement you both agreed on. Be persistent. If you are no longer able to communicate well with the debtor, move on to the next step without further delay.
5. **90-to-120 Days Past Due:** Get third party help. It is unlikely now that the patient will pay without the clout of a third party. You have a choice. You could take legal action, submit the debt to a collection agency, or write off the debt.

The longer you hold on to that delinquent account beyond this point, the less likely you will recover all the money that is owed you. Its collectable value shrinks at an alarming rate. A $100 account has a collectable value of $87 when it is 90 days past due. At six months past due, its collectable value has declined to $33. At a year, its worth $22. At two years, the value is just $3. (This is consensus data relative to the value of debts held by creditors pursuing normal internal collection activities. Professional collectors may achieve higher recoveries.)

Although I.C. System will accept older debts, it urges its clients to submit accounts when they are 60-to-120 days old. Right now, 48% of the debts submitted to I.C. by members of the WVSMA are two years or older. These accounts are difficult to work with, and inevitably I.C. System is unable to collect them as well as they would like.

I.C. System can help you train your office staff to better manage your accounts receivable with its videotape program, "The High Road to Collections," which they can use at their own pace. This video and accompanying resource manual explain how to use persuasion to collect, how to use collection letters and phone calls effectively, and how to recognize when you have lost communications with a debtor and need the assistance of a third party.

I.C. System serves clients in all 50 states, and its programs are offered as membership services by over 900 business and professional associations like yours. The programs are flexible and can be adjusted to fit specific accounts receivable situations.

If you would like to learn more about I.C. System and the ways it can benefit you, contact the WVSMA at (304) 925-0342 or call 1-800-685-0595.

Marilyn Seams
Communications Manager
I.C. System, Inc.
St. Paul, Minn.

Domestic violence topic for Lunch & Learn at Mid-Winter Conference in Charleston

"Anatomy of Domestic Violence" is the title of the Lunch & Learn program which will be presented on Saturday, January 20 at noon during the WVSMA's 1996 Mid-Winter Seminars and Scientific Clinical Conferences in Charleston at the Charleston House Holiday Inn. The Lunch & Learn programs have been very popular at the WVSMA's Annual Meeting for the past few years, so it was decided to add one of these events to this year's schedule for the Mid-Winter Seminars and Scientific Conferencs.

The special guest speaker on the subject of domestic violence will be Devika Malhotra, a professor of sociology at West Virginia University at Parkersburg (WVU-P). Malhotra is a native of India who migrated to the U.S. in 1961, after receiving her master's degree in sociology.

During her 19 years of teaching at WVU-P, she has taught 13 different courses and developed six new courses, including her most recent one entitled "Gender and Human Identity." In 1990, Malhotra received an Outstanding Professor Award from the West Virginia Legislature. She has also been the recipient of many other awards during her career, including the 1994 WVU-P Social Justice and Multicultural Awareness Award and the 1995 M.C. Buswell Award given by the Committee for Women's Concerns.

Malhotra

In addition to her master's degree in sociology, Malhotra obtained a Leadership Certificate in 1989 and a Gender Team Building Certificate in 1991 from the National Institute of Leadership Development in Phoenix, Ariz. She also completed the Total Quality Management Facilitator Training offered by WVU's Center for Entrepreneurial Studies and Development in 1993.

A past president of WVU-P's Faculty Senate for two years, Malhotra is actively involved in WVU-P's Social Justice Committee and the Committee for Quality Improvement in Education. She is a noted lecturer who conducts workshops on family issues, the changing roles of men and women, interpersonal skills, and cultural diversity.

The WVSMA's Mid-Winter Seminars and Scientific Conferences will again be presented in conjunction with the Fifth Annual Scientific Meeting of the West Virginia Chapter of the American College of Physicians. More information about this year's conference can be obtained by phoning the WVSMA at (304) 925-0342.

AMA creates new medical staff section

The AMA has announced the transition of its Hospital Medical Staff Section to the new Organized Medical Staff Section (AMA-OMSS).

This expansion, which was written into the AMA bylaws at its Annual Meeting, will allow the AMA to better meet the needs of physicians working not only in hospitals, but also in new health care delivery systems, which are emerging due to managed care.

Hospitals and health care delivery systems intested in designating an AMA-OMSS representative and/or attending the AMA-OMSS Interim Assembly Meeting, Nov. 30 - Dec. 4 in Washington, D.C., should call the AMA at 1-800-AMA-3211 and ask for the Department of Organized Medical Staff Services.

President names Amores to national arts post

President Clinton has announced his intent to appoint Dr. Constantino Y. Amores of Charleston to the Advisory Committee on the Arts of the John F. Kennedy Center for the Performing Arts.

Dr. Amores is a diplomate of the American Board of Neurological Surgery and a clinical professor of neurosurgery at WVU Medical School, Charleston Division. He received his M.D. degree with honors from the University of Santo Tomas in the Philippines in 1961.

A past president of the WVSMA, Dr. Amores currently serves as an AMA delegate. He is an active member of the Charleston Area Medical Center, where he has served as chief of the Department of Neurological Medicine, treasurer, chief of staff and trustee. In addition, Dr. Amores is the founding member of the Board of Governors of the Charleston Conservatory of Music and Fine Arts.

The Advisory Committee on the Arts of the John F. Kennedy Center for the Performing Arts advises and consults with the center's board of trustees about existing and prospective cultural activities. In addition, the members assist in fundraising and act as liaisons to performance groups and performing arts centers throughout the U.S.

The other individual appointed to the committee is Alison Deem, chair of the Board of Visitors of the College of Creative Arts at WVU.

WVSMA to conduct CME workshop in November

Robert E. Kristofco, M.Ed., a nationally-recognized CME consultant, will be the keynote speaker for *"Continuing Medical Education - Process and Practice,"* a CME workshop which will be presented by the West Virginia State Medical Association on Wednesday, November 1 at the Robert C. Byrd Health Sciences Center of WVU, Charleston Division.

This special workshop will include a site surveyor training workshop which WVSMA President Dr. James Helsley and WVSMA Associate Executive Director Nancie Albright are encouraging physicians to attend.

"I would like to stress to our membership the importance of serving as a CME site surveyor," Dr. Helsley said. Not only is the surveyor supported by our well-trained staff, the position allows an interested physician the opportunity to learn and teach the subject of CME. The mark of our profession includes the role of education. We, as physicians, should control our own continuing education, so I encourage as many physicians as possible to consider serving as site surveyors. The reward is the satisfaction of being on the cutting edge of CME," he added.

The workshop will begin with registration at 9:30 a.m., followed by a welcome at 9:55. Mr. Kristofco will then deliver the opening address, *"New Paradigm CME: Changes in Process and Practice."*

After a break at 10:45 a.m., concurrent workshops are scheduled for the rest of the morning. Topics will include *"Alternative Formats for Program Design,"* by Robin Rector, MA; *Step-by-Step Planning of a 1/2 to 2-day CME Program,"* by Thelma Wilson, M.A.; and *"Step-by-Step Planning of an Annual Meeting"* by Clara Clay.

Following an on-your-own lunch, the concurrent workshops will reconvene at 1:30 p.m. The choices for the afternoon will be *"Do's and Don'ts of Commercial Support,"* by Nancy Joiner and Clara Clay; *"The Five W's of Needs Assessment - Who, What, Where, When and Why,"* by Mr. Kristofco; and *"Site Surveyor Workshop (Part I),* by Dr. Terry Elliott and Ms. Albright.

A break will be offered at 2:30 p.m., and then the final segment of concurrent workshops are scheduled. Ms. Rector will be joined by Kari Long, M.B.A., for a session on *"Writing Educational Objectives;"* Mr. Kristofco and Ms. Wilson will team up to present *"Joint Sponsorship - Responsibilities of the Accreditation Provider;"* and Dr. Elliott and Ms. Albright will complete the second part of the *"Site Surveyor Workshop."*

Kristofco

At the end of these programs, panel discussions on *"Ethics in the Practice of CME"* and *"Planning for the Future -- Let's Talk Collaboration"* are planned beginning at 3:45 p.m. The workshop will then conclude after evaluations are completed at 4:30 p.m.

A brief biographical sketch of Mr. Kristofco begins in the next column, and pre-register details can be obtained by contacting Nancie Albright or Tim Allman at the WVSMA, (304) 925-0342.

Keynote speaker highlighted

Mr. Kristofco is a native of Altoona, Pa., who did undergraduate work in social and behavioral sciences at St. Frances College of Pennsylvania and earned a master's degree in social work from WVU. In 1990, he completed a program of study in the Institute for the Management of Lifelong Learning of the Harvard University Graduate School of Education.

Mr. Kristofco has been involved in CME activities since the late 1970s and is currently the executive director for Health Affairs Continuing Education of the University of Alabama at Birmingham, where he is also an associate professor and director of the Division of CME in the University of Alabama School of Medicine.

The author of a number of articles on needs assessment and marketplace issues in CME, Mr. Kristofco has co-authored a chapter on *"Marketing and CME"* for the *Primer on CME*, published for the Alliance for CME. He recently co-authored a chapter on *"Participation in Formal CME: Factors Affecting Decisionmaking"* in *The Physician As Learner*, which was published by the AMA.

A member of the National Task Force on Pharmaceutical Industry - CME Provider Collaboration, Mr. Kristofco is also a member of the Society of Medical College Directors of CME, the Alliance for CME and the Professional Convention Management Association.

Ree Cook Reiter honored at Annual Meeting

A special resolution honoring Ree Cook Reiter, immediate past executive director of the Ohio County Medical Society, was read during the Second Session of the WVSMA House of Delegates at the WVSMA's Annual Meeting at The Greenbrier.

Dr. Dennis L. Burech, past president of the Ohio County Medical Society, presented the resolution for his society. The resolution read as follows:

"It is with great pride and honor that I ask this association to recognize and honor Ree Cook Reiter, the immediate past executive director of the Ohio County Medical Society. During her years in this capacity, Ree gave untold hours in organizing, promoting, coordinating and giving overall direction to our society. To those of us fortunate to work with her during these years, we miss her presence greatly.

Therefore, be it resolved that the Ohio County Medical Society and the West Virginia State Medical Society wish her a return to good health and thank her with our deepest appreciation for her service to medicine."

9th FP Weekend/Sports Medicine Conference set

The Radisson Hotel in Huntington will again be the site for the Annual Family Practice Weekend and Sports Medicine Conference, which will be presented by the West Virginia Chapter of the American Academy of Family Physicians and the Family Medicine Foundation of West Virginia from November 10-12.

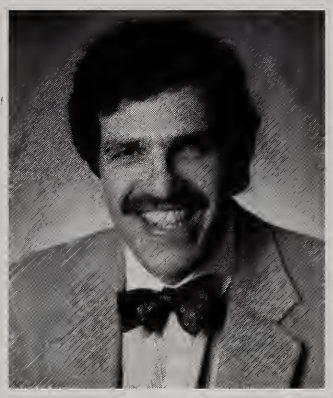
This is the 9th year for this event, which has been reviewed and is acceptable for 18.0 prescribed hours by the AAFP. AOA credit toward category 2-A for 18.0 hours is also approved.

Following registration and opening remarks, this year's CME program will officially start at 8:15 a.m. on Friday, November 10 with four lectures devoted to the subject of *"Sports Specific Injuries."* This session will be moderated by Program Chairman Dr. James Kyle and features speakers Donald Shell, M.D., of Hyattsville, Md.; Joe Leaman, ATC, of West Virginia Wesleyan College; Joseph Touma, M.D., of Huntington Ear Clinic; and Kyle Hegg, M.D.

A variety of luncheon meetings will then be held and the conference will reconvene at 12:55 p.m. with remarks by Mayor Jean Dean of Huntington. The lectures presented that afternoon will highlight *"Olympic Sports Medicine" and "Adolescent Sports Medicine,"* and will be moderated by Dan Martin, ATC. The first lecture will be presented by sports celebrity Dr. Glenn Terry, who is serving on the Atlantic Organizing Committee for the 1996 Olympic Games in Atlanta and is currently the charge physician for the games. Other speakers during the afternoon will include Dr. Kyle; Timothy Deer, M.D., of St. Francis Hospital in Charleston; Greg Elkins, M.D., of Lincoln Primary Care Center; John Spiker, M.D., of Morgantown Physical Therapy Associates; and Chandra Kumar, M.D., of the Asthma and Allergy Center in Charleston.

On Friday evening, a reception will be sponsored by Marshall University's Department of Family and Community Health at 5:30 p.m. The next morning, the CME sessions will begin at 8 a.m. with a lecture on *"Cardiovascular Disease"* by Robert DiBianco, M.D., of the Georgetown University School of Medicine. The other subjects to be discussed during the morning will be *"Rational, Cost Effective Antibiotic Prescribing for the Outpatient Setting,"*

Huntwork



Gantz

Beutner

"Allergies," "Pediatric Infections," and *"Rehabilitation Treatment Alternatives for Multiple Sclerosis Patients.*

At noon, a variety of luncheon meetings will again be offered, including one for spouses and guests on *"Estate Planning and Investment Strategies for the 90s"* hosted by Banc One Investment Management and Trust Group.

On Saturday afternoon, the sessions start at 1 p.m. with *"Advancements in Treatment of Depression,"* by Russell Voltin, M.D. of Psy Care Inc., of Charleston. This lecture will be followed by *"Advancement in Treatment of Osteoarthritis,"* by John Huntwork, M.D., of Huntington; *"Understanding and Managing the Asthmatic Patient* by David Skoner, M.D., of Children's Hospital of Pittsburgh; *Understanding the Ischemic Cascade,"* by Mark Geller, M.D., of West Penn Hospital in Pittsburg; and *"Diabetes and Hypertension As It Relates to Family Physicians,"* by Wayne Evron, M.D., of Joslin Diabetes Clinic in Pittsburgh.

That evening, a Family Practice Club Meeting is scheduled, as well as a special fund raising event for the Family Medicine Foundation of West Virginia in conjunction with the Huntington Blizzard hockey game.

Sunday's schedule will feature CME lectures beginning at 8:15 a.m. with *"Chronic Fatigue Syndrome with Immune Dysfunction,"* by Nelson Gantz, M.D., of the Polyclinic Medical Center in Harrisburg, Pa. Other subjects to be covered that morning are *"Treatment of GI Complications Caused by Non-Steroidals,"* by Howard Levine, M.D., of Rockville, Md.; *"The Diagnosis and Treatment of Impotence,"* by Ronald Hrebinko, M.D., of Pittsburgh; *"Optimal Management of Herpes Virus Infections: Prevalence and Differential Diagnosis,"* by Karl Beutner, M.D., of Long Beach, Calif.; and *"Optimal Management of Herpes Virus Infections: New Therapies,"* by David Whiting, M.D., of Dallas. The meeting will then conclude at 12:30 p.m. following the drawing for door prizes.

For more details, phone 776-1178.

Drs. Cordell, Marano named fellows of ACR

WVSMA President-Elect Dr. Ronald Cordell of Charleston, and Dr. Gary Marano of Morgantown, have been named as fellows of the American College of Radiology during ACR's annual meeting in Boston from September 9-13.

Dr. Cordell practices at Associated Radiologists, Inc. and is on the staff of CAMC. He is a clinical professor of radiology at the WVU School of Medicine, Charleston Division. Dr. Marano is the president of the Radiological Consultants Association and maintains a clinical appointment at the WVU School of Medicine.

Drs. Cordell and Marano are two of the 130 new fellows named by the ACR's Board of Chancellors. Fellowships in the ACR are awarded to members for significant scientific or clinical research in the field of radiology or significant contributions to its literature.

WVACS Officers

The officers attending the recent meeting of the West Virginia Chapter of the American College of Surgeons at The Greenbrier posed for a group portrait. On the first row are: David McLellan, M.D., councilor; Eric Mantz, M.D., governor; S. Willis Trammell, M.D., first vice president; Roger King, M.D., secretary/treasurer; Catalino Mendoza, M.D., councilor; and Generoso Duremdes, M.D., immediate past president. (Second Row) James Thomas, M.D., councilor; David Denning, M.D., second vice president; James Carrier, M.D., councilor; Paul Burke, president; Sharon Bartholomew, administrator; and Amabile Milano, M.D., president-elect. (Third Row) E. Phillips Polack, M.D., councilor; and Carl Kite, M.D., past president.

Otolaryngologists elect new officers, plan 1996 meeting

At their recent annual meeting at The Greenbrier, the members of the West Virginia Academy of Otolaryngology - Head and Neck Surgery, Inc. elected new officers and scheduled their next annnual meeting for May 25-27 at The Greenbrier.

The officers for 1996-97 include Stephen Wetmore, M.D., president; Phillip Stevens, M.D., vice president; F. Thomas Sporck, M.D., secretary-treasurer; and James Bland, M.D., William Morgan Jr, M.D., and Michael Hurst, M.D., directors.

For information about next year's meeting, please contact F. T. Sporck, M.D., P.O. Box 1628, Charleston, WV 25326-1628; (304) 342-7054, ext. 132.

TODAY'S THE DAY
Stop Smoking.
American Heart Association

Fifth Annual Vascular Surgery Conference

Symposium on Venous Diseases and Pulmonary Embolism Update

Saturday, October 28, 1995

Director:

Ali F. AbuRahma, M.D.
Professor of Surgery, Robert C. Byrd Health Sciences Center of West Virginia University/Charleston Division
Chief, Vascular Section
Medical Director, Vascular Laboratory
Charleston Area Medical Center

Location:

Robert C. Byrd Health Sciences Center of West Virginia University/ Charleston Division

For more information, please contact CAMC Continuing Education and Conference Services at (304) 348-9581.

Featured Speakers:

John J. Bergan, M.D.
Past President - The Society for Vascular Surgery and the American Venous Forum
Professor of Surgery, Loma Linda University Medical Center, Loma Linda, California
Clinical Professor of Surgery, University of California, San Diego
Uniformed Services, University of the Health Sciences/Bethesda

Robert W. Hobson, II, M.D.
President - American Venous Forum
Professor of Surgery,
Chief, Section of Vascular Surgery
New Jersey Medical School
Newark, New Jersey

Robert Rutherford, M.D.
President - International Society for Cardiovascular Surgery
Professor of Surgery,
University of Colorado Health Sciences Center
Denver, Colorado

Frank J. Veith, M.D.
President - Society for Vascular Surgery
Professor and Chief
Vascular Surgical Services
Montefiore Medical Center
Albert Einstein College of Medicine
New York, New York

Charleston Area Medical Center

Robert C. Byrd Health Sciences Center of West Virginia University/Charleston Division

Continuing Medical Education

Listed on this page are some of the upcoming CME programs for physicians which will be held in the state and region. Unless otherwise noted, these events are presented at the location under which they appear.

If you would like to have the CME programs offered by your organization printed in the *Journal*, contact Nancy Hill, managing editor, at 925-0342.

Charleston Area Medical Center - Charleston

October 28
"Fifth Annual Vascular Surgery Conference: Symposium on Venous Disease and Pulmonary Embolism Update"

November 2
(Teleconference) "Acetaminophen Hepatotoxicity," Brittain M. McJunkin, M.D.

November 2-3
"Pediatric Advanced Life Support Course Provider Course"

November 4
"Pediatric Advanced Life Support Course Provider Course"

Huntington Medical Community Foundation - Huntington

October 17
"Lung Cancer: A Surgeon's Perspective" Jake Lambert, M.D., (presented for the Williamson Memorial Hospital medical staff), The Brass Tree Restaurant, Williamson, 6:30 p.m.

October 24
"ALL: The Most Common Malignancy of Childhood," Andrew Pendleton, M.D., South Williamson Appalachian Regional Hospital, South Williamson, Ky., 5:30 p.m.

November 2
"Pneumonia and Chronic Pulmonary Obstructive Disease," Harry Tweel, M.D., (presented for the Putnam General Hospital medical staff), Hurricane, 7:30 a.m.

November 8
"Hip Fractures/Joint Replacement," John Mullen, M.D., and Nancy Mullen, RN, (presented for the Logan County Medical Society), Logan, 6 p.m.

November 16
"Inflammatory Bowel Disease," Richard Mailloux, M.D., (presented for the Pleasant Valley Hospital medical staff), Point Pleasant, noon

November 21
"Rural Health Care for the Elderly" Robert Walker, M.D., (presented for the Williamson Memorial Hospital medical staff), The Brass Tree Restaurant, Williamson, 6 p.m.

Marshall University - Huntington

October 20
"5th Annual Cancer Conference," St. Mary's Hospital, Soltis Room, 8 a.m. - 5:30 p.m.

October 21
"9th Annual MU School of Medicine Alumni Homecoming Weekend," Radisson Hotel, 7:30 a.m. - 11:30 a.m.

Robert C. Byrd Health Sciences Center of WVU - Morgantown

October 27
"1995 Appalachian Regional Neuro-Rehabilitation Symposium"

October 27-28
"OB/GYN Women's Health Symposium 1995"

October 28
"Fifth Annual N. LeRoy Lapp, M.D. Internal Medicine Teaching Days"

November 3
"Fall Cancer Conference"

November 3-4
"Neurosciences Teaching Weekend"

November 18
"Modern Perspectives on Low Back Pain"

West Virginia State Medical Association - Charleston

November 1
"Continuing Medical Education - Process and Practice, Robert C. Byrd HSC of WVU, Charleston

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *Charleston Area Medical Center, Charleston*

Fairmont ★ Fairmont Clinic, Oct. 18, 1 p.m., "Update on TB in the 90s," Melanie Fisher, M.D.

★ Fairmont Clinic, Nov. 15, 1 p.m., "Common Dermatological Problems," William Welton, M.D.

★ Fairmont General Hospital, Nov. 7, 7:30 p.m., "Chronic Fatigue Syndrome," Kathaleen Perkins, M.D.

Logan ☐ Logan General Hospital, Nov. 17, TBA

Man ☐ Man Appalachian Regional Hospital, Oct. 18, 6 p.m., "New Treatment for Sinus Problems," Austin Wallace, M.D.

Montgomery ☐ Montgomery General Hospital, Nov. 1, 12:30 p.m., "TBA," Jay Requarth, M.D.

New Martinsville ★ Wetzel County Hospital, Nov. 9, 7 p.m., "Breast Cancer: A Medical Disease," Edward Crowell, M.D.

Oak Hill ☐ Plateau Medical Center, Oct. 12, 6:30 p.m., "Hyperlipidemia," Mike Lewis, M.D.

Oakland, Md. ★ Garrett County Memorial Hospital, Oct. 27, 8 a.m., "Management of Obesity," Robert Hoeldtke, M.D., Ph.D.

Petersburg ★ Grant Memorial Hospital, Oct. 16, noon, (MDTV) "Diabetes and Hypertension," Rebecca Schmidt, D.O.

Philippi ★ Broaddus Hospital, Nov. 9, 1 p.m., "Initial Management Priorities in Poisoning and Overdose," Debra Paulsen, M.D.

Point Pleasant ☐ Pleasant Valley Hospital, Oct. 26, noon, "Update on Cervical Cancer," Michael Schiano, M.D.

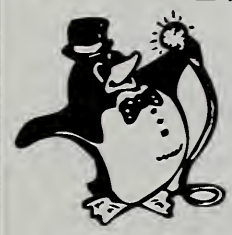
Waynesburg, Pa. ★ Greene County Memorial Hospital, 7 p.m., "Update on Organ Transplantation," Roger Riley, M.D., Ph.D.

White Sulphur Springs ★ The Greenbrier Clinic, Oct. 23, 4 p.m., "Update on Abalatable Arrhythmias in 1995," John Lobban, M.D.

**TBA - To Be Announced*

Don't Be Left Out on an Iceberg!

Mark your calendar now for the 1996 Mid-Winter Seminars and Scientific Conferences



January 19-21, 1996

Charleston House Holiday Inn - Charleston

Join us for:

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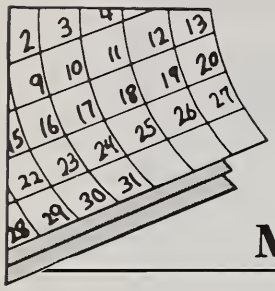
- Physician/Public Session
- Lunch and Learn
- "Controversies in Medicine"
- "Potpourri of Topics"

The West Virginia State Medical Association's Mid-Winter Sessions will be held in conjunction with the Fifth Annual Scientific Meeting of the West Virginia Chapter of the American College of Physicians. Call the WVSMA at (304) 925-0342 for more information.



Medical Meetings

October

13–Sleep Medicine '95 (sponsored by Riverside Methodist Hospitals, the Sleep Medicine Research Foundation, Inc., and Ohio Sleep Medicine Institute), Columbus

13-14–Contemporary Management of Common Respiratory Problems, (sponsored by the University of Cincinnati), Cincinnati

13-15–Advances in Sonography (sponsored by the Society of Radiologists in Ultrasound), Chicago

15-18–17th Annual Meeting of the Society for Medical Decision Making (sponsored by George Washington University), Phoenix, Ariz.

19-21–New Techniques and Concepts in Cardiology (sponsored by the American College of Cardiology), Washington, D.C.

19-22–Heartland Rural Health Forum (sponsored by the National Rural Health Association), Kansas City, Mo.

20-22–Cancer Update (sponsored by SMA), Williamsburg, Va.

21-25–American Society of Anesthesiologists, Atlanta

22-25–American Neurological Association, Washington, D.C.

22-27–American College of Surgeons, New Orleans

23-27–American College of Occupational and Environmental Medicine's 47th Annual State-of-the-Art Conference, Seattle

30–Laser Surgery Seminar XII (sponsored by The Eye and Ear Clinic of Charleston, Dept. of Surgery at the Robert C. Byrd HSC of WVU, and CAMC), Charleston

29-Nov. 2–American College of Chest Physicians, New York City

29-Nov. 3–Ortho-Neuro Weeklong Review (sponsored by the MRI Education Foundation, Inc.), Cincinnati

31-Nov. 5–American Medical Women's Association, Seattle

November

1–Continuing Medical Education -- Process and Practice (sponsored by the WVSMA), Charleston

3-5–7th Annual Infectious Disease Review Course, Bethesda, Md.

7-12–American Association of Gynecologic Laparoscopists, Orlando

9-11–The Joint Commission's National Forum on Health Care Quality, Chicago

9-11–Bone Mass Measurement in Osteoporosis and Other Bone Diseases (sponsored by the National Osteoporosis Foundation), Los Angeles

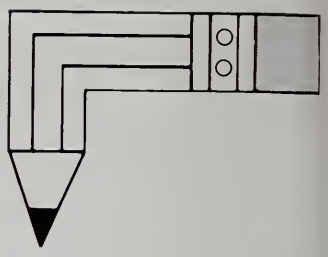
9-12–42nd Annual Meeting of the Academy of Psychosomatic Medicine, Palm Springs, Calif.

11-15–American College of Allergy and Immunology, Dallas

15-19–SMA, Kansas City, Mo.

For More Information . . .
Contact the Journal at (304) 925-0342

Poetry Corner



Let It Rain

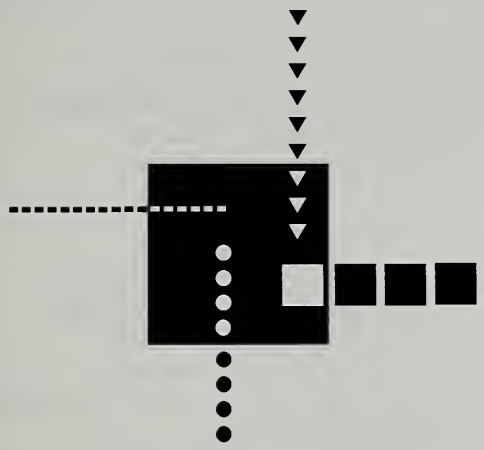
Pausing, interrupted by the sprinkle of the rain
First a rush, not a roar, just a crinkle on the pane,
When the pattern varied the daily rewind
Of tasks, 'til long days ending remind
In autumn days of dark grasses and butterflies,
The leaf on dried ground aflutter lies.
When life moves on and highways slide
Can you go home (again) as days divide?
O' West Virginia, once upon a time,
When hills ringed home, and you were mine,
On thirsty walks I drank from fountain stream
Or passed by smoky plumes of mountain steam
Recalling good, forgetting folly and slights
Beneath the drifting peaks of solid heights.
Realizing, memories passing time haunts
Like a poem having only so many fine points.
At last the wispy trails and clouds above the wind
Made one forget all but the love of friend.
Was that your hand? Tho, your lie lingers,
I wish to trace your face with my fingers.
Despairing, deciding to be friend to none
Where trickling rivulets began to run
In glistening molten seas of snows
Even water, undecided which way to seize, froze.

Lee L. Neilan, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Organized Medical Staff Section

Twenty Sixth Assembly Meeting
November 30–December 4, 1995
Washington Hilton and Towers Hotel
Washington, DC



Representation, Education and Networking

Send an AMA member physician representative from your hospital or health care delivery system to the 1995 Interim American Medical Association Organized Medical Staff Section (AMA-OMSS) Assembly Meeting to be held November 30 - December 4, 1995 in Washington, DC. Don't pass up this opportunity to participate in AMA's policy-making process and make a difference in the way your representative organization responds to managed care and other important issues facing today's physician. You can also gain valuable knowledge and make useful contacts by attending OMSS educational programs and networking functions.

With the growth of managed care, the merging of hospitals, and the corporatization of medicine, the traditional roles and responsibilities of the medical staff are being challenged. To help physicians respond effectively, OMSS's educational program titled, "Creating the Future and Getting There First," will focus on changing the medical staff paradigm, thinking in the future tense, and strengthening the physicians' leadership role in the governance of hospitals, integrated delivery systems, and managed care organizations. More specifically, the session will address:

- The changing environment and the value of self-governance;
- How to reengineer and improve medical staff functions and processes;
- The attributes of a successful self-governing physician organization (PO);
- The components of governance and resources needed to develop a community-based PO;
- What criteria should be utilized in making partnering decisions; and
- How to manage risk, respond to legal and logistical challenges, and raise capital.

For new insight into how to increase physician involvement in your community attend the AMA-OMSS Interim Assembly Education Program on Friday, December 1 from 2:30 pm to 5:30 pm in Washington, DC.

"The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians."

"The AMA designates this medical education activity for up to 3 credit hours in Category 1 of the Physician's Recognition Award."

For more information please call **800 AMA-3211** and ask for the AMA's Department of Organized Medical Staff Services.

American Medical Association
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Department of Health & Human Resources

Bureau for Public Health News

This page of material is submitted and paid for by the Bureau for Public Health.

Statistics show infant mortality rate at all-time low in 1994

West Virginia's infant mortality rate dropped to an all-time low in 1994, as improvements continue in the accessibility, availability and utilization of prenatal care for pregnant women in the state.

The *West Virginia 1994 Provisional Vital Statistics*, a report released by the Bureau for Public Health, shows that 126 West Virginia infants died before their first birthday last year, compared to 187 infant deaths in 1993. The infant mortality rate, or number of infant deaths per 1,000 live births, was 6.2 in 1994, down from 8.6 in 1993 and the previous low of 8.1 in 1991. The national infant mortality rate was 8.0 in 1994.

According to the report, more than 93% of the pregnant women in the state last year received prenatal care in the first or second trimester of their pregnancy, which is one of the main reasons why more babies are surviving. Continued recruitment of obstetricians and nurse-midwives, improved recognition and follow-up of high-risk pregnancies, and the availability of transportation to prenatal and infant health care in rural areas have also been cited as reasons for the improved rates in prenatal care and low infant mortality.

Other figures in the 1994 provisional report show the state's birth rate of 11.3 births per 1,000 population still lags behind the national average of 15.3; the West Virginia death rate declined to 10.4, while the national death rate increased to 8.8; the marriage rate among West Virginians was 5.7, far below the national rate of 9.1; and the state's divorce rate was 5.0, compared to 4.6 nationally.

The provisional vital statistics report is released each summer as a first look at the number of births, deaths, marriages and divorces among West Virginians in the previous year. A final report is released once complete statistics are obtained from all reporting entities. The report is used to monitor health care trends and determine needs for targeted problem areas.

For more information on the 1994 provisional vital statistics, or to receive a copy of the report, call the Bureau's Health Statistics Center at (304) 558-9100.

New HIV testing sites established

Five new AIDS Prevention Centers (APCs) have been opened around West Virginia, making it easier for more people to be tested for HIV, the virus that causes AIDS. There are now 20 APCs offering HIV antibody testing and counseling in the state.

The new APCs are located at the following sites:

Braxton County Health Dept. - Sutton
Grant County Health Dept. - Petersburg
Harrison-Clarksburg Health Dept. - Clarksburg
McDowell County Health Dept. - Wilcoe
Putnam County Health Dept. - Hurricane

The other sites in the state are located at:

Berkeley County Health Dept. - Martinsburg
Cabell-Huntington Health Dept. - Huntington
Fayette County Health Dept. - Fayetteville
Greenbrier County Health Dept. - Fairlea
Kanawha-Charleston Health Dept. (2 sites) - Charleston
Logan County Health Dept. - Logan
Marshall County Health Dept. - Moundsville
Mercer County Health Dept. - Bluefield
Mid-Ohio Valley Health Dept. - Parkersburg
Monongalia County Health Dept. - Morgantown
Raleigh County Health Dept. - Beckley
Randolph-Elkins Health Dept. - Elkins
Wheeling-Ohio Health Dept. - Wheeling
Bureau for Public Health AIDS Program - Charleston

The West Virginia AIDS Program funds the APCs, where a person can be tested for free and anonymously if they prefer, and the results of the test are held in the strictest confidence as provided by state law. The centers employ nurses trained to offer appropriate counseling to persons who come to be tested, whether the test turns out positive or negative. People who test positive are offered baseline immune system testing, as well as information about support groups and resources available to help them stay healthy for as long as possible.

For more information about AIDS in West Virginia, call the Bureau's AIDS Program at 1-800-642-8244.

Bus carries immunization messages

The Kanawha Valley Regional Transportation Authority now has a colorfully-decorated bus in its fleet which carries messages to parents, health care providers and community about the importance of immunizing children against deadly diseases. This bus will be in operation through June 1996 and is a joint project of the Bureau for Public Health and the Kanawha-Charleston Health Department.

The first bus of its kind in the state, officials hope it will be duplicated by other communities to help spread the message about preventing mumps, measles, rubella, polio, diphtheria, tetanus, pertussis (whooping cough), haemophilus influenza Type B (Hib), hepatitis B and now chickenpox. Currently, 66% of children nationwide and half of all children in West Virginia do not receive timely vaccine protection from these diseases. The state and national goal for 1996 is to have 90% of all children properly immunized before their 2nd birthday.

For more information about the childhood immunization schedule, call your local health department or health care provider, or call the West Virginia Immunization Program at (304) 558-2188 or 1-800-642-3634.

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Half-Day Seminar
1:00 p.m. - 5:30 p.m.
Reception following seminar
**

This seminar is provided at **no charge** to attendees.

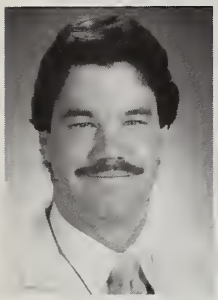
1:00 - 1:15	Arrival	
1:15 - 1:30	Opening remarks	
1:30 - 2:00	**FEDERAL HEALTH CARE REFORM AND ITS IMPACT ON WEST VIRGINIA**	Sally Richardson, U.S. Dept. Health & Human Services
2:00 - 2:30	**CURRENT ISSUES AT THE WEST VIRGINIA HEALTH CARE COST REVIEW AUTHORITY**	David W. Forinash Executive Director HCCRA
2:30 - 3:00	**THE ROLE OF THE U.S. ATTORNEY IN HEALTH CARE**	Rebecca A. Betts, U.S. Attorney Southern District, West Virginia
3:00 - 3:30	**RESPONDING TO GOVERNMENT INVESTIGATIONS**	David K. Higgins, Esq.
3:30 - 3:45	Break	
3:45 - 4:15	**UPDATE ON HEALTH CARE REGULATORY ISSUES**	Kent J. George, Esq.
4:15 - 4:45	**OVERVIEW OF MANAGED HEALTH CARE AND INTEGRATED DELIVERY SYSTEMS IN WEST VIRGINIA**	Charles M. Johnson, Jr., Esq.
4:45 - 5:15	**HEALTH CARE AND ANTI-TRUST LAW**	Mark D. Kindt, Esq., former Regional Director, FTC
5:15 - 5:30	Concluding remarks	
5:30	Reception	

REGISTRATION REQUIRED
REGISTRATION IS LIMITED. PLEASE CALL
SALLY GALL at (304) 344-5800, ext. 462
TO REGISTER YOUR ATTENDANCE
BY OCTOBER 24, 1995

WEST VIRGINIA UNIVERSITY HEALTH SCIENCES CENTER

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

Grant to assist Health Right with funding; two new clinics planned


Smego

A four-year grant from The Robert Wood Johnson Foundation will help the three Health Right clinics in Morgantown, Charleston and Wheeling, and fund efforts for two new clinics in the state.

The WVU School of Medicine is one of 37 organizations nationwide selected by the foundation to participate in the "Reach Out" project. This project is intended to encourage physicians to take a leadership role in assuring that everyone in their local areas has access to health care.

Dr. Raymond Smego, associate professor of medicine at WVU and volunteer medical director of Morgantown Health Right, will direct the project, and Pat White, executive director of West Virginia Health Right in Charleston, has been named project administrator. The Morgantown and Charleston clinics, along with Wheeling Health Right, will benefit in the first year from an effort to identify unmet health care needs in their communities and to recruit additional physician volunteers to provide services. Also during the first year, the project will identify two communities in the state where new clinics are needed.

Each of the existing Health Right clinics is an independent, community-based organization, and depends primarily on volunteers to provide health care. In 1994, nearly 40,000 West Virginians received care at one of the three sites, and now with the new project, hopefully 10% more patients can be served at the current clinics each year and 20,000 more patients cared for at the two new sites.

New director named for Center on Aging

Hermanova

Dr. Hana Hermanova has been named director of the WVU Center on Aging.

Dr. Hermanova has been regional advisor for health care for the elderly, disability, and rehabilitation at the World Health Organization's regional office in Copenhagen, Denmark, since 1983. She has also been on the faculty at Charles University, Prague, Czech Republic, where she earned her M.D. in 1959.

The WVU Center on Aging includes the 65-Plus Clinic in the Physician Office Center; educational programs for health and social services professionals who work with the elderly; and research programs on Alzheimer's disease and other ailments affecting older people. It also supports programs in Morgantown and other cities, such as the Senior Companion Program and the Community Living Initiatives Corp.

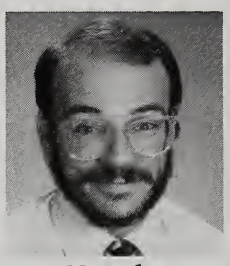
Bequest to benefit medical research

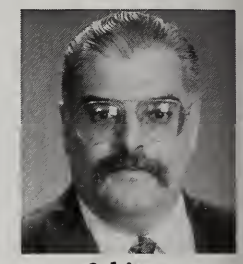
Three research projects at the WVU School of Medicine will be the first beneficiaries of a bequest by Beatrice P. Madera of Morgantown. Madera, who died in 1992, left $323,000 to the WVU Foundation for medical research.

The School of Medicine has recently released $140,000 of these funds to:

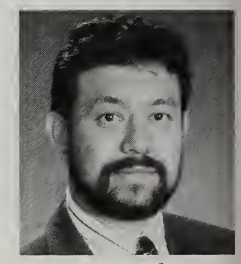
* David Kreulen, Ph.D., who will lead a team to help study neuropedtide Y in transgenic rats
* John Barnett, Ph.D., professor and chair of microbiology/immunology, who will lead a team to study the effects of the herbidcide propanil on mammals' immune systems.
* Christine Bayliss, Ph.D., professor of physiology, who was granted $31,519 to hire a full-time assistant to create a facility to culture human kidney and blood vessel cells.

Charleston Division adds four new faculty


Montalto


Schiano

Shipley


Hernandez

The Charleston Division of the Robert C. Byrd Health Sciences Center of WVU has appointed the following physicians to the faculty: Norman Montalto, Family Medicine; Michael Schiano, Obstetrics and Gynecology; and Dianna Shipley and Jaime Hernandez, Department of Medicine.

Uro-gynecology Center established

A new Uro-gynecology Center has been created at WVU to treat cases of female urinary incontinence. According to Dr. James Holehouse, the tertiary center will offer a comprehensive approach, using surgery, medications and various forms of patient training.

"Most family physicians and gyncologists are comfortable treating common forms of stress incontinence," Dr. Holehouse said. "At WVU, we are available to see the more difficult cases, such as women with anatomical anomalies or those who have had unsuccessful surgeries," he added.

Diagnosing the cause of urinary incontinence is sometimes difficult, and the center will use a "systemmetrics" approach to evaluation based not only on patient histories and examinations but on computer monitoring.

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Marshall University School of Medicine

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

Plans underway for $16 million cancer treatment center

Preliminary design work is underway for development of a major new weapon in the fight against cancer in the Tri-State area.

Joan C. Edwards, a Huntington businesswoman and philanthropist, has joined with Cabell Huntington Hospital President W. Don Smith II and Marshall President J. Wade Gilley to discuss plans for the James F. Edwards Institute for Cancer Treatment in honor of her late husband. This facility is expected to cost more than $16 million, and will be built as part of the medical complex on Hal Greer Boulevard housing Cabell Huntington Hospital and the new $30 million Marshall Medical Center.

The center is being built with a gift left to Cabell Huntington Hospital in trust by Mr. Edwards, who was owner and chief executive officer of Namaco Industries of Huntington.

"Mr. Edwards entrusted us with the task of fulfilling his vision of an accessible, state-of-the-art center dedicated to meeting the needs of cancer patients," Smith said. "The members of this committee are the ones who will help us translate that vision into reality."

Smith stated that he is appointing a planning and advisory committee to be chaired by the MU School of Medicine Dean Dr. Charles H. McKown Jr., to guide development of the facility and its programming. He also announced that Cabell Huntington Hospital is making a $100,000 grant to the committee so that it can consult with national experts to determine the best range of services for the center. The funds will also allow the panel to begin work with space planners and archiects.

NBBJ of Columbus, Ohio, is doing the preliminary design work for the cancer institute.

New scholarship program to benefit rural health care

A new scholarship program, which is designed to provide a shot in the arm to rural health care, has been created at Marshall University by the A.T. Massey Coal Company, the Massey Foundation and the Fluor Foundation.

This new program, Doctors for Our Communities ("DOC"), will give medical students up to $60,000 in loans that they can repay by practicing primary care in a coal field community in which Massey Coal Company has an operation. This plan currently includes towns in Boone, Logan, McDowell, Mingo, Nicholas, Raleigh and Wyoming counties in West Virginia, and in Martin and Pike counties in Kentucky.

"This program goes right to the heart of improving health care in underserved areas," said Dr. Patrick I. Brown, Marshall's associate dean for academic and student affairs. "It focuses precisely on the people most likely to become doctors in rural areas: the people who already live there. The DOC program relieves the financial burden of medical education that presently discourages so many young people who would make excellent physicians."

The DOC program will provide loans to one entering medical student each year. Preference will be given to students who graduated from a high school in a county in which Massey has an operation. If a student chooses not to practice in one of the eligible communities, he or she is given 10 years after completion of their residencies to repay the loan.

"Doctors for Our Communities represents a strong partnership, linking Massey and its long-standing support of medical care with Marshall and its successful focus on primary care medicine," said Dr. Charles H. McKown Jr., dean of the School of Medicine. "We see this program as an ideal way to help rural communities develop and nurture the medical resources they need."

Center established for handicapped children

A Children's Developmental Center has been created in Huntington to serve multiple handicapped children.

A cooperative project between the Department of Pediatrics and Cabell Huntington Hospital, the center will be staffed by pediatric specialists in neurology, developmental medicine, learning disabilities, and psychiatry. It will provide neonatal follow-up, as well as physical, speech and occupational therapy.

Rhoten receives Fullbright grant

William B. Rhoten, Ph.D., chair of the Department of Anatomy, Cell and Neurobiology, has received a Fulbright grant to lecture at the University of Zimbabwe in Harare, Zimbabwe, from January through December 1996.

Dr. Rhoten will teach courses in human anatomy, histology and cell biology for students in medical, nursing, and rehabilitative programs. He will assist with curriculum development, particularly production of self-directed learning manuals.

ARC honors Walker

Dr. Robert Walker of MU has been named as one of eight "People who made a difference" in Appalachia in the 30th anniversary publication of the Appalachian Regional Commission.

Walker was honored for his contributions to rural health care as a provider, a mentor and an advocate. Calling him a "one-man billboard for the possibilities of rural medicine," the magazine cited Walker's role in starting the Lincoln Primary Care Center, his contribution to dramatically decreasing the county's infant death rate, and his work with students through his teaching and leadership at Marshall.

Michele P. Craig, executive director of the Region II Planning and Development Council in Huntington, nominated Walker for the honor.

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Diplomate, American Board of Otolaryngology

MEDICAL AND SURGICAL TREATMENT OF EAR DISEASES

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Alliance News

TEAM: Together Everyone Accomplishes More

Together we can each effect greater change, contact more people, accomplish a greater amount of work and have a lot more fun than anyone of us could possibly accomplish alone. The Alliance has provided a means of forming networks that enable us to have an effect upon our county, state and nation. With one act we can affect so many through our federated alliance.

The Alliance has the ability to accomplish goals for the betterment of society. We can enact legislation to promote health care and provide a nurturing environment for our youth, elderly, and married couples. Our work with the West Virginia Tobacco Control Coalition and the notice on marriage licenses against spousal abuse are just two examples of our efforts. This year, we will focus on adolescents as we work to provide a more nurturing environment for them to mature within. We have a resolution that is currently being written into a bill which will prohibit the sale of indecent audio material to our minors. We are also working with the State Board of Education to provide a Conflict Resolution Plan that teaches alternatives to physical responses to anger. These are just some of the projects the WVSMA Alliance is working on this year.

Responding to a request from the AMA Alliance, we have asked each county to establish October 11, 1995 as SAVE (Stop America's Violence Everywhere) Day with a mayoral proclamation. We have also asked each county to highlight adolescents on this special day. The WVSMA Alliance has received a gubernatorial proclamation for West Virginia. These seem like such small steps, yet from these proclamations the AMA Alliance will request a National SAVE Day similiar to the National Smoke Out Day. This is how we work together on the county, state and national levels. Throughout the nation, Alliance members are working to effect great changes and constantly striving to improve our evolving society - - **Together Everyone Accomplishes More**.

What do you need to do in order to join the Alliance? All you need to do is to be the spouse of a physician and pay your dues. You may not have much time at this point in your life or you may have lots of time to help us work. You may only be able to contribute your dues at this point and we respect that. You may be very worried about the global situation and feel alone and powerless to effect change. Alone you are powerless. We need you to make the world a better place - - together. We need you in order to be strong, both financially and in numbers, in order to accomplish our goals. When we stand together, we are heard loud and clear. We need you to join us to make our voice even stronger. You will receive the inner satisfaction of knowing you are making the world a better place. Come join our **TEAM - - *THE ALLIANCE TEAM* - - THE BEST TEAM**. We won't let you down. We are the **A-TEAM - - THE BEST TEAM**.

You are invited to attend the WVSMAA's Fall Board Meeting in Wheeling from October 25-26. Come and see how the WVSMAA works. For further information, you may phone the Louann Fagundo at 243-1494 or Kathy Fortunato at 242-2032, who are chairing the meeting. Of course, you may also always phone Winnie Morano, the WVSMAA's executive director, at 925-0342, for assistance.

Linda Elliott
WVSMAA President

SAVE

STOP AMERICA'S VIOLENCE EVERYWHERE

American Medical Association Alliance, Inc.

Pledge Against Violence

I pledge

to SAVE Today

and Stop America's Violence Everywhere.

I will strive

to end this crisis

that threatens the health

of all people

of the United States of America.

*Signed*_____

*Date*_____

WESPAC Members

The following is a list of the physicians and Alliance members who have recently made contributions to WESPAC:

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A Dollar A Day Club - $365

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J. Alan Cochrane
Craig Morgan

Central
Charles Lively

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Stephan Thilen
Haven Wall Jr.

Harrison
James Bryant
James Bland
Florencia C. Lopez
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Checks for all PAC contributions should be payable to WESPAC. If your practice is a corporation or professional association, contributions must be written on a **PERSONAL** check. Contributions are not limited to the suggested amount. Neither the AMA, the WVSMA nor the component medical societies will favor or disfavor anyone based on the amount of or failure to make PAC contributions. Contributions are subject to Federal Election Commission Regulations and the West Virginia Secretary of State Regulations.

Contributions for WESPAC/AMPAC are not deductible as charitable contributions for federal income tax purposes. A portion of your WESPAC contribution is sent to AMPAC thus enrolling you as an AMPAC member as well.

Annual Audit 1994

The annual audit of the West Virginia State Medical Association for the calendar year 1994 has been completed by Ernst & Young LLP of Charleston. The complete audited financial statements including the report of independent auditors is as follows:

REPORT OF INDEPENDENT AUDITORS

To the Council
West Virginia State Medical Association

We have audited the accompanying balance sheets of West Virginia State Medical Association (WVSMA) as of December 31, 1994 and 1993, and the related statements of revenues and expenses—unrestricted fund, changes in fund balances, and cash flows—unrestricted fund for the years then ended. These financial statements are the responsibility of WVSMA's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of WVSMA at December 31, 1994 and 1993, and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

Ernst & Young LLP

April 19, 1995

BALANCE SHEETS–WVSMA

	December 31 1994	1993
UNRESTRICTED FUND		
ASSETS		
Cash and cash equivalents—Note 4	**$ 947,935**	$ 908,628
Accounts receivable	**31,594**	63,802
Other assets	**17,196**	14,734
Land, building, and equipment, net—Note 2	**603,229**	623,455
	$1,599,954	$1,610,619
LIABILITIES		
Dues collected in advance	**$ 696,705**	$ 496,926
Other deferred revenue	**525**	57,262
Medical scholarship obligation	**9,163**	9,163
Accounts payable	**20,361**	59,580
Income taxes (refundable) payable	**(4,058)**	8,000
Accrued expenses and other liabilities	**35,282**	15,353
Note payable to bank—Note 4	**452,335**	492,185
	1,210,313	1,138,469
FUND BALANCE		
Undesignated	**389,641**	472,150
	$1,599,954	$1,610,619
RESTRICTED FUND—NOTE 1		
ASSET		
Investment in common stock	**$ 4,250**	$ 4,250
FUND BALANCE		
Endowment	**$ 4,250**	$ 4,250

See notes to financial statements.

STATEMENTS OF REVENUES AND EXPENSES—UNRESTRICTED FUND–WVSMA

	Year Ended December 31 1994	1993
REVENUES		
Dues	**$ 727,026**	$ 738,458
Professional liability services—Note 5	**140,000**	140,000
Contributions:		
Conferences and meetings	**7,000**	8,996
Litigation	**74,037**	—
Interest and investment	**24,769**	39,693
Exhibit space income	**35,230**	48,600
Advertising	**48,096**	44,877
Registration fee income	**48,290**	53,248
Commission income	**22,558**	34,557
Other revenues	**14,426**	7,688
Total revenues	**1,141,432**	1,116,117
EXPENSES		
Salaries and wages	**323,559**	282,377
Legislative	**47,221**	50,585
Interest expense	**22,780**	38,660
Publishing and printing	**96,435**	98,947
Convention speakers and supplies	**91,806**	76,638
Legal and accounting	**149,981**	89,007
Travel	**65,674**	86,437
Malpractice	**41,353**	38,884
Employee benefits	**92,873**	78,835
Depreciation and amortization	**28,572**	26,652
Equipment lease expense	**38,153**	31,710
Postage	**37,704**	37,760
Payroll taxes	**25,604**	24,679
Office supplies	**19,067**	23,114
Telephone	**18,142**	17,806
President's stipend	**10,000**	9,500
Property taxes	**12,380**	13,129
Liability insurance	**6,647**	6,730
Medical students'/residents' subsidies	**15,627**	11,915
Computer repairs and maintenance	**6,675**	8,499
Utilities	**7,128**	6,236
Other expenses	**61,155**	56,828
Total expenses—net	**1,218,536**	1,114,928
(Deficiency) excess of revenues over expenses before taxes	**(77,104)**	1,189
Income tax provision:		
Federal	**4,042**	5,040
State	**2,915**	2,944
	6,957	7,984
Deficiency of revenues over expenses	**$ (84,061)**	$ (6,795)

See notes to financial statements.

STATEMENTS OF CHANGES IN FUND BALANCES–WVSMA

	Unrestricted Fund	Restricted Endowment Fund
Balance at December 31, 1992	$477,409	$4,250
(Deficiency) excess of revenues over expenses	(6,795)	1,536
Transfer from endowment fund to unrestricted fund	1,536	(1,536)
Balance at December 31, 1993	472,150	4,250
(Deficiency) excess of revenues over expenses	**(84,061)**	**1,552**
Transfer from endowment fund to unrestricted fund	**1,552**	**(1,552)**
Balance at December 31, 1994	**$389,641**	**$4,250**

See notes to financial statements.

STATEMENTS OF CASH FLOWS—UNRESTRICTED FUND—WVSMA

	Year Ended December 31 1994	1993
OPERATING ACTIVITIES		
Deficiency of revenues over expenses	**$ (84,061)**	$ (6,795)
Adjustments to reconcile deficiency of revenues over expenses to net cash provided by (used in) operating activities:		
Depreciation and amortization	**28,572**	26,652
Gain on sale of investments	**—**	(7,952)
Decrease (increase) in accounts receivable	**32,208**	(27,831)
(Increase) decrease in other assets	**(2,462)**	1,985
Increase (decrease) in dues collected in advance	**199,779**	(55,832)
(Decrease) increase in income taxes payable	**(12,058)**	294
Decrease in medical scholarship obligations	**—**	(4,500)
(Decrease) increase in accounts payable	**(39,219)**	31,024
(Decrease) increase in accrued expenses and other liabilities	**(36,808)**	39,379
Transfer from Endowment Fund	**1,552**	1,536
Net cash provided by (used in) operating activities	**87,503**	(2,040)
INVESTING ACTIVITIES		
Proceeds from sale of investments	**—**	207,987
Purchases of equipment	**(8,346)**	(8,747)
Net cash (used in) provided by investing activities	**(8,346)**	199,240
FINANCING ACTIVITIES		
Repayment of note payable to bank	**(39,850)**	(10,431)
Net cash used in financing activities	**(39,850)**	(10,431)
Net increase in cash	**39,307**	186,769
Cash and cash equivalents at beginning of year	**908,628**	721,859
Cash and cash equivalents at end of year	**$947,935**	$908,628

See notes to financial statements.

NOTES TO FINANCIAL STATEMENTS—WVSMA

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Cash and Cash Equivalents: Cash and cash equivalents are comprised of short-term certificates of deposit and money market accounts recorded at cost, which approximates market. Bank balances as of December 31, 1994, approximated $1,006,000, of which approximately $131,000 was covered by federal depository insurance. The remaining balance is unsecured.

Allowance for Doubtful Accounts: WVSMA values its accounts receivable at net realizable value by expensing amounts determined to be uncollectible in the period of determination.

Land, Building, and Equipment: Land, building, and equipment are recorded at historical cost. Depreciation is computed by the straight-line method using estimated useful lives ranging from 5 to 35 years. The cost of maintenance and repairs is charged to income as incurred, and significant improvements are capitalized.

Recognition of Revenue: Members are billed in advance for the subsequent year's dues, which are treated as earned in the period to which they relate. All dues received prior to January 1 are reported as dues collected in advance.

Other Deferred Revenue: WVSMA received approximately $17,000 and $57,000 in 1994 and 1993, respectively, in voluntary contributions from its members in support of pending litigation involving newly passed legislative rules and regulations that affect the practice of medicine in West Virginia. The 1993 receipts were recorded as deferred revenue until the related expenditures were made in 1994. In 1994, total cumulative contributions of $74,037 were used to fund, in part, litigation costs. The related costs are reflected under the legal and accounting expense caption on the 1994 statement of revenues and expenses.

Medical Scholarship Obligation: Until 1987, WVSMA provided scholarships to students attending Schools of Medicine at West Virginia and Marshall Universities for the purpose of defraying expenses. A liability for the remaining scholarship obligation is a part of the unrestricted fund.

Fund Balance: The Endowment Fund, a restricted fund, was established to pay for the guest speaker at the annual meeting and consists of equity securities stated at cost, which approximates market value.

Reclassifications: Certain amounts in the 1993 statement of revenues and expenses have been reclassed to conform to 1994 presentation. Such reclassifications did not affect fund balance as of December 31, 1993, or deficiency of revenues over expenses for the year then ended.

2. LAND, BUILDING, AND EQUIPMENT

A summary of land, building, and equipment, and the related allowance for depreciation as of December 31, is as follows:

	1994	1993
Land	**$ 141,247**	$ 141,247
Building and improvements	**635,585**	635,585
Furniture and equipment	**236,619**	228,273
	1,013,451	1,005,105
Less allowance for depreciation	**(410,222)**	(381,650)
	$ 603,229	$ 623,455

3. FUTURE MINIMUM RENTALS UNDER OPERATING LEASES

WVSMA leases office and computer equipment under noncancellable operating leases with terms of one year or more. The following is a schedule by years of minimum future rentals for the years ending December 31:

1995	$26,044
1996	22,989
1997	22,242
1998	11,683
Total minimum future rentals	$82,958

Total minimum future rentals do not include contingent rentals which may be assessed under the office equipment lease on the basis of usage in excess of stipulated minimums. Contingent rental expense in 1994 and 1993 approximated $3,800 and $7,000, respectively. Rental expense in 1994 and 1993 approximated $38,000 and $32,000, respectively.

4. NOTE PAYABLE TO BANK

Terms of the agreement underlying the note payable to bank provide for interest at 1% above the annual percentage yield of certificates of deposit and other balances, if any, securing the loan. The note is repayable in 60 monthly installments of $5,200 (including principal and interest) followed by a balloon payment or refinancing of the then outstanding loan balance. The loan is primarily secured by a first deed of trust on the building which has a net book value approximating $433,500 at December 31, 1994. In addition, the loan is collateralized by a $300,000 certificate of deposit and money market account with a balance approximating $607,000 at December 31, 1994.

Interest paid approximated $23,000 in 1994 and $39,000 in 1993. Scheduled principal payments on the note payable in each of the next four years ending December 31 are as follows:

1995	$ 41,594
1996	43,636
1997	45,777
1998	321,328
	$452,335

5. PROFESSIONAL LIABILITY SERVICES

WVSMA has separate agreements with Continental Insurance Agency (CNA) and Acordia of West Virginia (Acordia) to provide educational and marketing services to WVSMA's members relating to professional liability insurance. Under these agreements, WVSMA is to receive up to $100,000 a year from each company. WVSMA recognized income of $100,000 from CNA and $40,000 from Acordia in 1994 and 1993.

6. RETIREMENT PLAN

WVSMA is a participant in a Prototype Corporate Defined Contribution Retirement Plan (the Plan). All employees of WVSMA are covered by the Plan as long as they are at least 21-years-old and have completed six months of service. WVSMA's contribution approximated $31,000 in both 1994 and 1993 based on approximately 10% of the total compensation of all eligible participants. Employees are vested at the rate of 20% for each completed year of service, up to 100% vesting after five years of service.

7. INCOME TAXES

Revenues of WVSMA are generally exempt from federal income tax under Section 501(c)(6) of the Internal Revenue Code. However, certain income, primarily advertising revenues and income received under agreements with insurance providers for their educational/marketing services and use of WVSMA's membership lists, is considered unrelated business income and is taxable to the extent it exceeds allocable expenses.

WVSMA paid income taxes approximating $18,400 in 1994 and $7,000 in 1993.

Obituaries

Albert C. Esposito, M.D.

Dr. Albert C. Esposito, 82, a Huntington ophthalmologist who devoted much of his life to establishing a medical school at Marshall University, died September 20 at his home after a long illness.

Dr. Esposito was born in Pittsburgh and received his B.S. degree at the University of Pittsburgh. In 1938, he graduated Cum Laude with his M.D. degree from Loyola University Stritch School of Medicine in Chicago.

After an internship at St. Francis Hospital in Pittsburgh, Dr. Esposito served a residency under Dr. Albert D. Frost at the Ohio State College of Medicine, where he was appointed an instructor in 1944. In addition, from 1942-46 Dr. Esposito served in the Medical Corps during World War II and earned the rank of major.

In 1946, Dr. Esposito opened his ophthalmology practice in Huntington, where he cared for patients until his retirement on January 1, 1994. Dr. Esposito was elected and served two terms in the West Virginia House of Delegates in order to realize his dream of creating the Marshall University School of Medicine, which he alone had worked toward for more than a quarter century.

"Dr. Esposito's death is a terrible loss to all of us close to Marshall," said Dr. Charles McKown, dean of Marshall's School of Medicine. "The loss is especially great for those of us who saw Dr. Esposito's long years of arduous effort and watched his dream come to fruition in the unfolding of the School of Medicine.

"He will always be recognized as the father of the School of Medicine, and will also be remembered as an accomplished professional and a wonderful citizen who served our area with dedication. He was a man of huge stature in terms of things he accomplished for this community."

Marshall University awarded Dr. Esposito an honorary Doctor of Science degree during ceremonies on January 10, 1978, when the university formally opened its School of Medicine. He was also inducted into the Huntington Hall of Fame in 1989.

Dr. Esposito served as president of the WVSMA from 1964-65, and during his career also served as president of the West Virginia Academy of Ophthalmology, the American Association of Ophthalmology, the Southern Medical Association and Cabell County Medical Society. He was a diplomate of the American Board of Ophthalmology and a fellow of the Society Francaise D'Ophthalmolgie in Paris; the Oxford Congress of Ophthalmology in Oxford, England; the American College of Surgeons; and the Pan American and the International Congress of Ophthalmology. In addition, Dr. Esposito was a diplomate of the American Academy of Ophthalmology and Otolaryngology, where he also served on the teaching staff.

During his years of caring for patients, Dr. Esposito received many awards, including the American Academy of Ophthalmology's Outstanding Humanitarian Service Award, which he was scheduled to received on October 30.

Dr. Esposito was married for 55 years to the former V. Elizabeth Dodson of Lexington, Ky. His other survivors include three children, Bettina Esposito Kelly and her husband, Peter F. Kelly of Huntington, Gregory Charles Esposito of Atlanta, and Mary Alice Esposito Tartler of Silver Spring, Md.; four grandchildren, Albert Charles Esposito II and his wife, Judy, of Banner Elk, N.C., Joseph Peter Kelly and Matthew Albert Kelly, both of Huntington, and Courtney Esposito of Stone Mountain, Ga.; one brother, Edward Esposito of Grove City, Pa.; one sister, Mrs. Dorothy Gallo of Pittsburgh; and several nieces and nephews.

Expressions of sympathy may be made in memory of Dr. Esposito to the Marshall University Foundation Inc., c/o the Dr. A. C. Esposito Lectureship Fund, 400 Hal Greer Blvd., Old Main 323, Huntington, WV 25755-6300; or to the Huntington Museum of Art, 2033 McCoy Road, Huntington, WV 25705.

Richard Hamilton, M.D.

Dr. Richard Hamilton, 93, of St. Marys died August 27 at his residence.

Dr. Hamilton was born in Grantsville and attended West Virginia University and received his M.D. degree from Harvard Medical School. In 1930, he established his medical practice in St. Marys, where he practiced for more than 50 years.

An Army medical officer in the South Pacific during World War II, Dr. Hamilton was awarded the Bronze Star medal and cluster. He retired from the Army with the rank of lieutenant colonel.

During his career, Dr. Hamilton received the silver buffalo and the silver beaver for his work with the Boy Scouts of America. As a member of the Red Cross, he was instrumental in establishing the blood bank in Pleasants County.

In addition to being a member of the WVSMA and a past president of the Parkersburg Academy of Medicine, Dr. Hamilton was a member of the AMA, St. Marys Kiwanis Club, Eureka Lodge No. 40, AF & AM of Grantsville, and St. Marys Presbyterian Church, where he was an elder.

Dr. Hamilton is survived by one son, Richard Hamilton of Denver, Colo.; one daughter, Francis White of Cardif, Calif.; seven grandchildren and two great-grandchildren. He was preceded in death by his wife, Edna Douglas Hamilton in 1990, and 10 brothers and four sisters.

The family suggests memorial contributions to the Pleasants County Educational Trust Fund, Pleasant County Board of Education, 202 Fairview Drive, St. Marys, WV 26170.

West Virginia Medical JOURNAL

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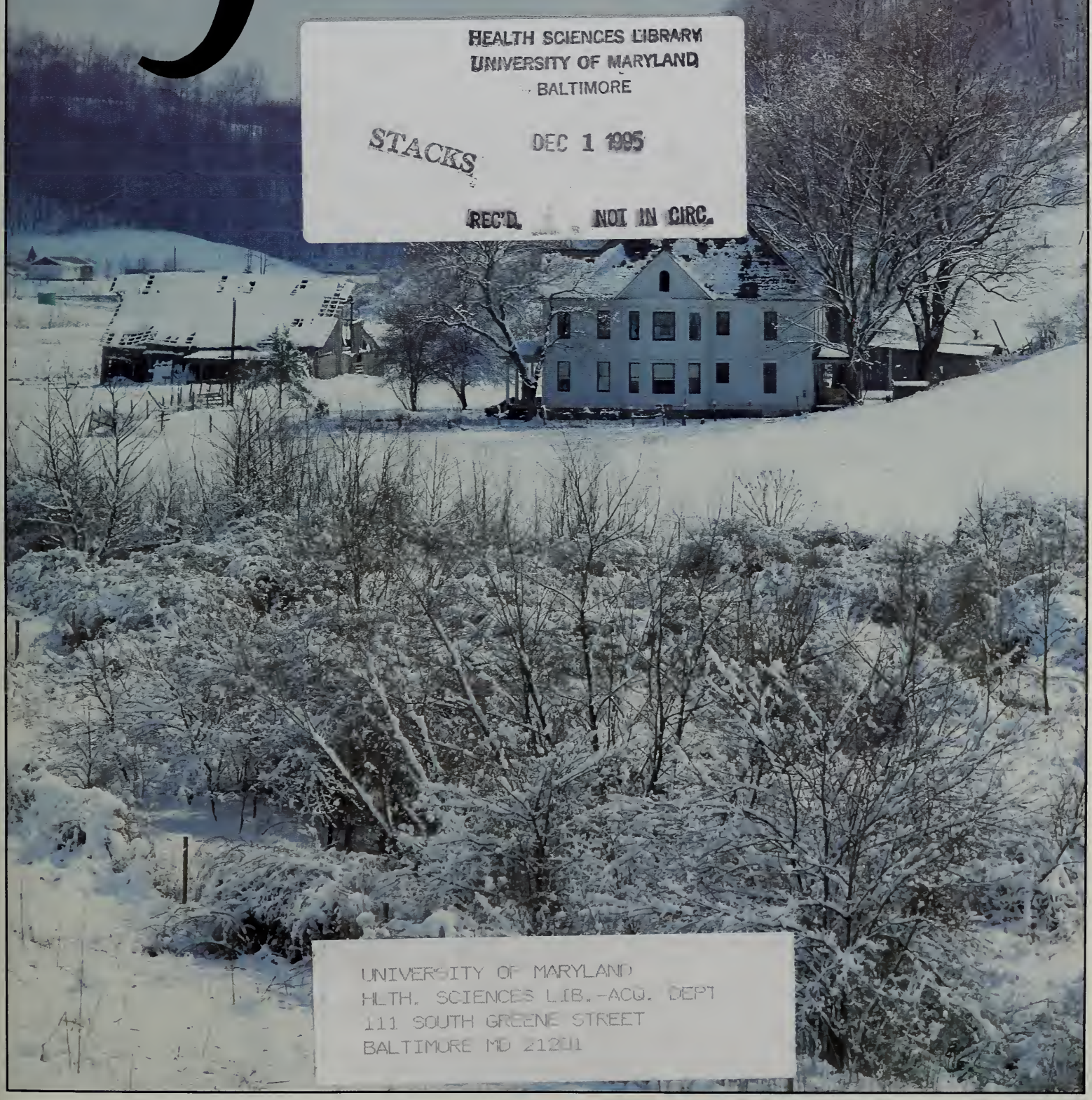

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West Virginia Medical
JOURNAL

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A picturesque snow scene in Clay County. Photo by *Arnout C. Hyde Jr.* of Charleston.

Two cases of malignant lymphoma complicating autoimmune (Hashimoto's) thyroiditis

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Abstract

The occurrence of lymphoma of the thyroid in a setting of autoimmune thyroid disease is being recognized with increasing frequency. The usual presentation is a rapidly enlarging goiter. This article describes two cases of this condition and emphasizes how prompt diagnosis and treatment can yield satisfactory results.

Introduction

Goiters are a common finding in clinical practice and can usually be treated in a non-emergent manner. The most common underlying conditions are autoimmune thyroiditis, multinodular goiter and Graves' Disease. However, the emergence of a rapidly growing thyroid mass, especially in the setting of an autoimmune thyroid condition (1,2), suggests the possibility of a more serious and potentially lethal problem, so the differential diagnosis should always include cancer (Table 1).

Lymphomas rank high as a cause of fulminant growth of a goiter (2,3). As a result, the clinician must pursue an aggressive approach in order to obtain any possibility of cure.

Table 1. Cancers Causing Rapid Goiter Enlargement

Most Common Tumors

1. Lymphomas
2. Anaplastic Carcinoma

Less Common Tumors

1. Metastatic Cancers
2. Papillary-Follicular Thyroid Cancer
3. Medullary Thyroid Cancer

To illustrate the importance of considering lymphomas as a complication of autoimmune thyroiditis, we present the cases of two patients we treated at St. Mary's Hospital in Huntington.

First case

A 71-year-old white woman was brought to St. Mary's Hospital with a rapidly enlarging neck mass. She had a 20-year history of an asymptomatic goiter requiring no treatment and had no history of head and neck irradiation or exposure to chemicals.

One year earlier, this patient had experienced tremors and nervousness, and examination revealed a goiter of about 60 gm (three times normal) with an irregular contour. At that time, she had no lid lag, lid retraction or palpitations. Deep tendon reflexes were not brisk, but a fine tremor of the outstretched hands was present. She had denied recent weight loss.

Thyroid function tests had revealed a low normal TSH with a high normal FT4. The TSH was performed prior to widespread availability of highly sensitive TSH assays, so these results were suggestive, but not conclusive, of thyrotoxicosis. Therefore, a TRH stimulation test was done which demonstrated a suppressed response indicative of thyroid hormone excess.

A thyroid scan and 24-hour uptake showed 12.1% ^{123}I uptake (normal = 5%-30%) with a patchy distribution. Antimicrosomal antibodies were 89.4 units/ml (normal less than 0.3) and antithyroglobulin antibodies were 16.8 units/ml (normal less than 0.3). This finding revealed a picture of mild thyrotoxicosis (suppressed TSH) resulting probably from autonomous production of thyroid hormone in a multinodular gland.

She was placed on PTU 150 mg BID as an outpatient to deplete the gland of thyroid hormone and plans were made to treat her with radioiodine in the near future. Several months had elapsed, then, over a period of three weeks she noticed a rapid enlargement of her goiter. In addition, two days prior to being brought to St. Mary's, she had experienced shortness of breath, a choking sensation and neck pain. She reported no loss of consciousness, chest pain, change in voice or dysphagia.

When she was examined at the hospital, the left lobe was three times its normal size, but the right lobe was six to eight times its normal size; a huge increase from baseline. Right and left posterior cervical lymphadenopathy was also detected.

Laboratory studies

Her laboratory studies indicated a WBC 6.5, Hb/Hct 14/42, Plt. 270,000, TSH 1.21 (0.38-6.15 IU/ml), and T4 8.9 (4.9-10.6 mcg/dl). A radiograph showed right-sided tracheal deviation with a large soft tissue mass in the neck.

A low patchy uptake was revealed by the thyroid scan, and the CT of the neck and thorax indicated an enormous mass emanating from the thyroid, engulfing the trachea, and displacing it to the right (Figure 1). The mass also extended into the retrosternal.

The mass was biopsied and the histology showed neoplastic large non-cleaved lymphocytes with staining characteristics positive for leukocyte common antigens and B cell markers. This finding was consistent with malignant non-Hodgkin's lymphoma (Figure 2).

She was treated with external irradiation with satisfactory results.

Second case

A 72-year-old white woman was admitted to St. Mary's Hospital with an expanding thyroid mass of recent onset. She had a history of stage I chronic lymphocytic leukemia (CLL) which had been treated conservatively, and had no history of irradiation or chemical exposure.

This patient reported developing a small and slowly enlarging goiter for six years, but she had experienced no symptoms of thyroid dysfunction such as temperature intolerance,

Figure 1. A CT of the patient's neck in the first case shows a large thyroid mass surrounding the trachea.

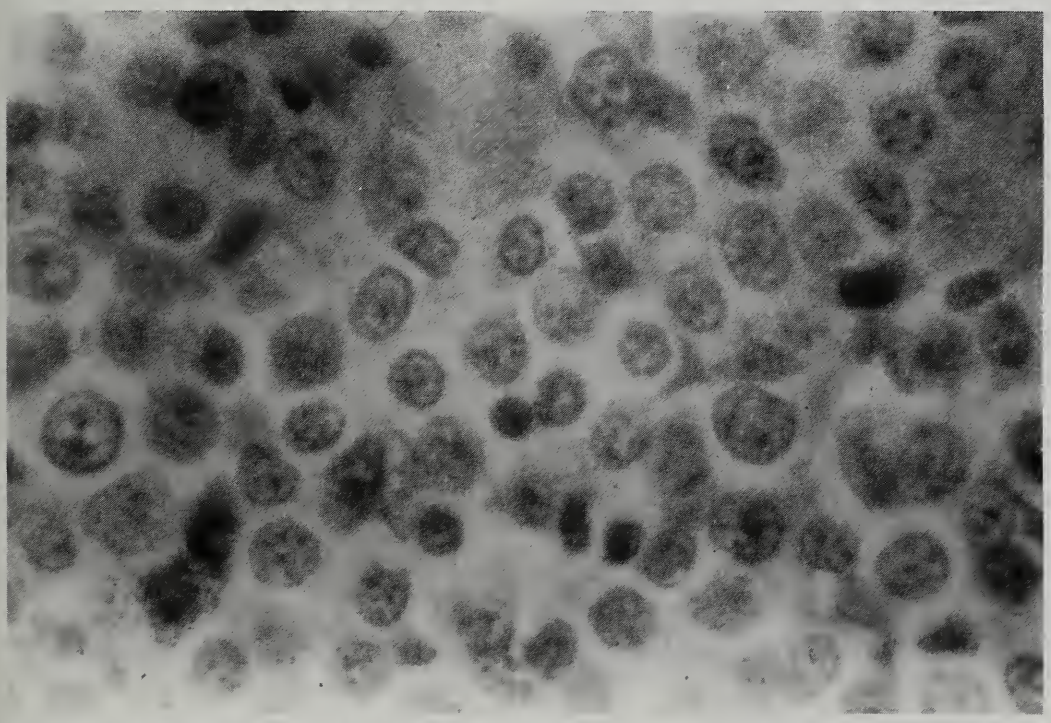

Figure 2. Neck mass biopsy of the patient in the first case shows malignant non-Hodgkin's lymphoma.

sweatiness, palpitations, constipation or skin changes. She was started on levothyroxine (Synthroid) 25 mcg daily one month prior to admission. Nevertheless, she noted continued enlargement of her goiter, and two weeks before she was admitted to the hospital, the mass underwent an explosive growth and doubled its size. She also had experienced three days of choking sensation, dysphagia, facial and neck swelling, and mild shortness of breath, which resulted in her admission. Her other medications included theophylline (Theo-Dur) 200 mg orally BID and diltiazem (Cardizem) 30 mg orally TID.

The physical exam revealed no signs of thoracic outlet obstruction, but the neck exhibited an enormous goiter approximately eight to ten times normal (about 200 gm). Its consistency was firm, not fixed, with limited motion on swallowing. There were lymph nodes present in the right posterior cervical chain which were not fixed or tender. No bruits, no stridor, and no signs of superior vena cava syndrome were present. Lungs and heart were normal, and the rest of the physical was otherwise unremarkable. She had reported no recent loss of weight.

Laboratory studies

This patient's laboratory studies showed a TSH of 10.8 (0.35-7.0 IU/ml), T4 7.2 (4.9-10 mcg/dl), and her antimicrosomal antibodies were elevated. Her CBC indicated a WBC of 44, Hb/Hct 13/36, and platelets 153,000. Peripheral smear demonstrated "smudge" cells and increased lymphocytes.

In addition, neck and chest radiographs revealed a large, soft tissue mass with tracheal deviation, and a radioiodine scan showed a patchy uptake. The CT scan of her neck and thorax demonstrated a large thyroid mass with substernal extension and tracheal compression plus localized adenopathy.

When this mass was biopsied, large cell histiocytic malignant lymphoma was revealed which involved the thyroid with histologic components of lymphocytic thyroiditis (Hashimoto's thyroiditis) (Figure 3). Biopsy of cervical lymph nodes showed well differentiated small-cell malignant lymphoma consistent with CLL (Figure 4).

This patient was treated initially with surgical debulking and chemotherapy.

Discussion

Cancers of the thyroid are an uncommon cause of goiters and usually present as slow-growing painless nodules with few local symptoms. Two exceptions are thyroid lymphoma and undifferentiated carcinoma, which often have a more dramatic presentation.

Lymphomas may account for up to 5%-10% of thyroid malignancies (1-4). On the other hand, chronic lymphocytic thyroiditis (Hashimoto's thyroiditis) is an extremely common cause of goiters which is frequently accompanied by hypothyroidism and can occur at any age. Histologically, it is characterized by a diffuse invasion of lymphocytes with destruction of thyroid follicles and fibrosis. Follicular cells may enlarge and exhibit abundant granular cytoplasm with a pink hue. These are the Hürthle or Askanazy cells.

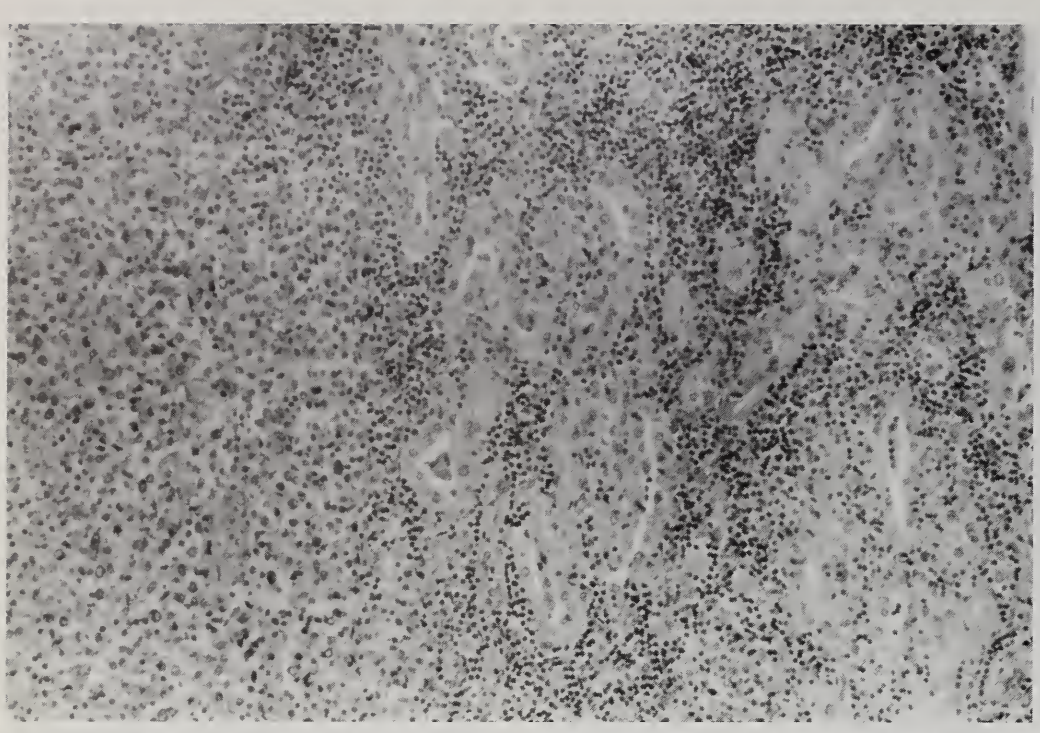

Figure 3. Neck mass biopsy of the patient in the second case reveals the coexistence of lymphoma contiguous with lymphocytic thyroiditis.

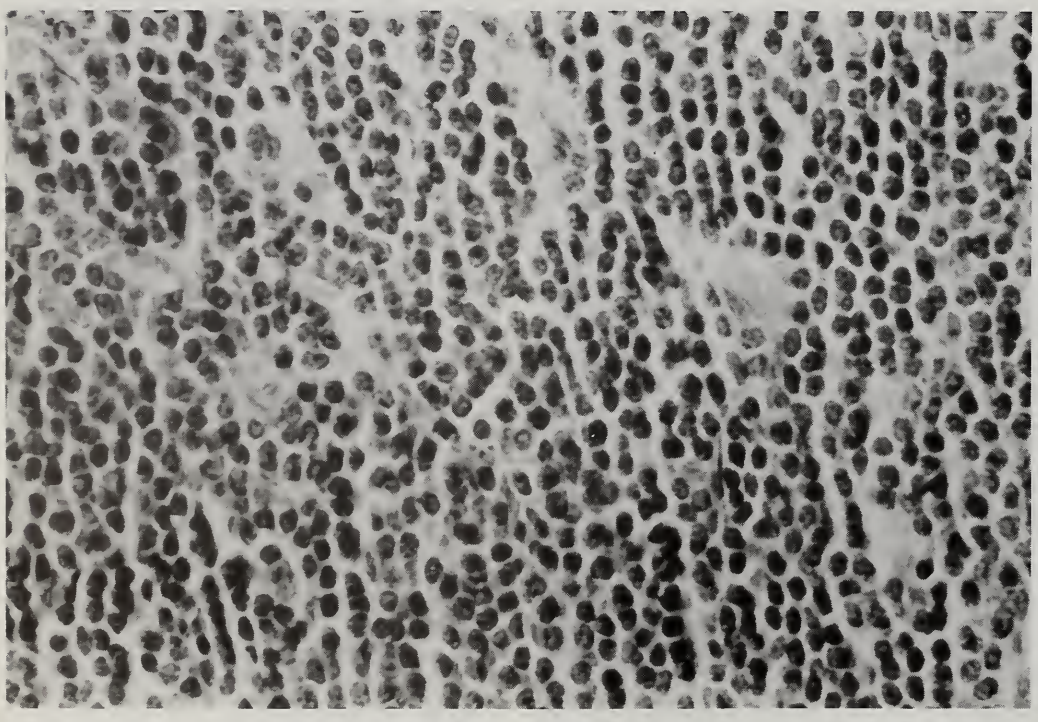

Figure 4. Lymph node biopsy of the patient in the second case shows well differentiated small-cell lymphocytic lymphoma, consistent with CLL.

A large portion of the invading lymphocytes are B cells with numerous plasma cells. These later cells may be responsible for producing the characteristic antithyroid antibodies usually found in Hashimoto's thyroiditis. This entity is part of a spectrum of immunoregulatory thyroid disturbances which can have opposite results, exemplified by Graves' Disease and lymphocytic thyroiditis.

The association of lymphoma of the thyroid and Hashimoto's thyroiditis is being recognized with increased frequency (1-3). This association raises the possibility of a common pathogenetic link and encourages vigilance among clinicians treating goiters with an autoimmune component since there may be up to a 70-fold increased risk of thyroid lymphoma in patients afflicted with Hashimoto's thyroiditis (2).

The usual type of thyroid lymphoma is a non-Hodgkin's diffuse histiocytic lymphoma of B cell origin (2). It has been postulated that the chronic antigenic process within the Hashimoto's gland may somehow favor the emergence of a clone of cells with lymphoproliferative malignant potential (1).

The prototypical patient with a thyroid lymphoma is a female in her sixth or seventh decade (5). Frequently, a goiter has been present for many years either clinically silent or hormonally hypofunctional. This placid chronicity can be interrupted by a rapid and inexorable growth of the gland either globally or restricted to one lobe. Depending on the concern of the patient or physician and the speed of growth, a period of weeks to months can elapse. The gland is usually firm to hard and sometimes fixed. It may be painful or indolent and can expand in any direction, including posteriorly and retrosternally.

Often the trachea is displaced, invaded and even obliterated. Without intervention the subject can literally choke to death due to strangulation of the upper airway by the malignancy. Frequent complaints include dysphagia, pain, hoarseness, stridor, dyspnea and a choking sensation. Many patients experience facial suffusion, dizziness, and lightheadedness upon raising their arms above the head (Pemberton's sign).

Lymphadenopathy can frequently be detected, especially in the cervical region. The lymphoma can be localized, but may also exhibit a more disseminated distribution. A frequent accompanying feature is hypothyroidism, but some patients can be clinically and biochemically euthyroid.

In order to initiate appropriate therapy and maximize the chance for a cure, it is imperative to make a rapid diagnosis. The most immediate concern is to prevent obliteration of the upper airway and prevent asphyxia as well as hemorrhage (3). The best method is via a biopsy of the mass (6).

Frequently, surgery is needed to debulk and decompress the neck area and to alleviate symptoms. Irradiation is extremely efficacious for relief of tracheal obstruction. Chemotherapy is also an important modality depending on the stage of the disease.

The prognosis depends on the age of the patient and the extent of disease. The malignancies limited to the thyroid can potentially be cured with thyroid resection and/or irradiation, but disseminated

lymphoma is obviously more difficult to eradicate. One recent report found 61% of 52 patients relapse-free after five years, and that the initial bulk of the tumor was the most important prognostic factor for relapse (7).

The survival of patients with thyroid lymphoma is superior to that of patients with other undifferentiated thyroid malignancies that may exhibit meteoric growth, particularly anaplastic carcinoma, where little more than palliation can be offered.

Conclusion

The two cases presented illustrate the value of considering lymphoma in the differential diagnosis of a rapidly enlarging goiter. It seems clear that an association between malignant lymphoma and chronic lymphocytic thyroiditis exists. Therefore, vigilance should be maintained among clinicians caring for this common thyroid disorder. Histologic diagnosis offers a quick guide to therapy which often yields gratifying results with significant cure potential.

In conclusion, physicians should always consider lymphoma, especially in the setting of underlying autoimmune thyroiditis, when they are confronted with a rapidly enlarging goiter.

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Radiofrequency catheter ablation in pediatric patients with supraventricular arrhythmias

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Abstract

Radiofrequency (RF) ablation of foci leading to abnormal cardiac rhythms is rapidly becoming the procedure of choice in the management of arrhythmias in adults. This report reviews our initial experience with RF ablation in the pediatric population.

Introduction

Supraventricular tachycardia (SVT) is a general term used in describing arrhythmias that arise in the atrium, the atrioventricular junction, or involve an accessory connection between the atria and ventricles. In the pediatric population, SVT is seen more frequently than ventricular tachycardia.

Children can present with SVT throughout early childhood as well as adolescence. The majority of children that present with SVT experience the tachycardia frequently enough that it may lead to hemodynamic compromise, therefore warranting medical attention. In these children, the mainstay of therapy has been antiarrhythmic medications with occasional surgical intervention in cases refractory to medical management.

Previous reports in the *West Virginia Medical Journal* (1-3) have outlined the use of RF ablation in treatment of adults with arrhythmias. The purpose of this report is to review our initial experience in using radiofrequency ablation in the treatment of pediatric patients with supraventricular arrhythmias.

Methods

From April 1992 to August 1994, 14 patients at WVU's Children's Hospital underwent a total of 17 radiofrequency ablation procedures (Table 1).

The selection criteria for determining the use of radiofrequency ablation for these pediatric patients included:

1. Failure to gain adequate control of the SVT using conventional antiarrhythmic medications;
2. Wolff-Parkinson-White Syndrome presenting with atrial fibrillation and rapid conduction; or
3. SVT in combination with complex congenital heart disease.

Patients ranged in age from 5.5 months to 16.5 years (1.9 ± 4.2 yrs). There were seven females and seven males. Weights ranged from 7.8 kg to 80 kg (49.9 ± 20.3). The number of medications tried prior to RF ablation ranged from 0 to 5 with a mean of 2.6.

Procedures

After informed consent, patients were brought to the catheterization laboratory and were sedated by anesthesiology (n = 4) or a combination of intravenous mediazolam (Versed) and fentanyl (n = 10). Intravenous sheaths were placed percutaneously. Venous access included the right and left femoral veins, the right internal jugular vein and/or the left subclavian vein. A femoral artery was also cannulated for BP monitoring.

Intracardiac electrode catheters were then placed at the high right atrium, the bundle of His, the RV apex and coronary sinus. In the one infant who underwent this procedure (patient # 9, Table 1), a transesophageal

Table 1. Demographics of the 14 Pediatric Patients Undergoing RF Ablation.

PATIENT	PROCEDURE	AGE	SEX	WEIGHT	MEDS	SVT
1	1	15	F	44 kg	B,V,D	EAT
2	2	12	M	57 kg	B,V,D,N	CBT
2	3	13	M	58 kg	B,V,D,N	WPW
3	4	16	F	77 kg	B,D	CBT
4	5	16	M	49 kg		WPW
5	6	13	F	75 kg	B,D	CBT
6	7	11	M	37 kg	B	CBT
7	8	15	M	80 kg	D,F	AVNRT
7	9	15	M	80 kg	D,B,F	AVNRT
8	10	9	F	26 kg	D,B	EAT
9	11	0.5	F	8 kg	D,B,Q,F,A	WPW
10	12	14	F	32 kg	D,B,V	CBT
11	13	16	M	62 kg	D,B,V,Q,F	PJRT
12	14	13	M	56 kg	B,N	WPW
13	15	6	F	32 kg	B,D,V	CBT
13	16	6	F	33 kg	B,D,V	AVNRT
14	17	13	M	42 kg	V	CBT

MEDS: A = amiodarone B = beta block D= digoxin F = flecainide
N = disopyramide Q = quinidine V = verapimil

SVT: AVNRT = atrioventricular node reentry CBT = concealed bypass tract
PJRT = permanent form of junctional reciprocating tachycardia WPW = Wolff-Parkinson-White

bipolar catheter was used for pacing and recording, and only two intracardiac catheters were employed. These catheters were then connected to a Midas (Lenexa, Kan.), multichannel recording system and up to 16 simultaneous intracardiac electrograms were recorded and analyzed.

Next, patients underwent a standard electrophysiology study. Once baseline studies were complete, attempts were made to induce and map the tachycardia. The induction and mapping varied based on the type of arrhythmia. In patients with accessory pathways, one or more of the following were employed:

1. In manifest pathways (WPW), the rhythm was mapped in normal sinus rhythm looking for an accessory pathway potential;
2. In concealed as well as manifest accessory pathways, mapping was performed during tachycardia, looking for the shortest Ventricular-Atrial (V-A) interval and/or an accessory pathway potential; or
3. Ventricular pacing was used to look for the shortest V-A interval during retrograde conduction across the accessory pathway.

In those patients with ectopic atrial tachycardia, the timing of the atrial electrogram was compared to the earliest surface P-wave. The ectopic focus often had an onset 20 - 40 msec prior to the onset of the surface P-wave.

Once the site of earliest activation or an accessory pathway potential was localized, the patient underwent attempted ablation using 16-20 watts of energy delivered via the unipolar tip of the ablation catheter. If no change was noted after 10-15 seconds, the power was turned off and the mapping catheter was repositioned to "fine tune" the electrogram, and a repeat attempt was made.

This procedure continued until the focus was localized, at which time the patient received a full 60 seconds of energy. If after an extended period of time the focus could not be localized (3 - 6 hours depending on the patient's age), the procedure was deemed a failure and the catheters were removed.

If the ablation was considered successful, patients were monitored with catheters for 30 minutes. This was followed by an aggressive stimulation protocol both on and off isoproterenol in an attempt to induce the original arrhythmia, or to bring out a second focus. If no further tachycardia could be induced, the catheters were removed and the patient was transferred back to the general pediatric floor.

Patients were discharged from the hospital 24-48 hours following the procedure.

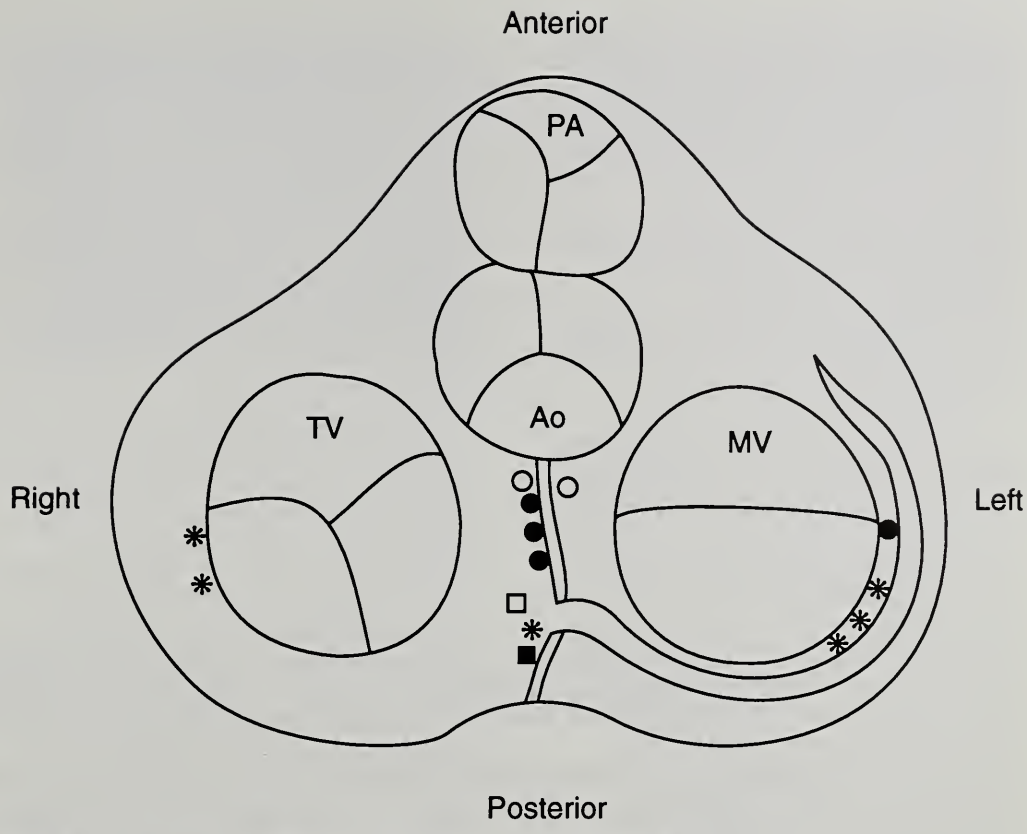

Figure 1. Location of Accessory Connection or Ectopic Focus.

PA = pulmonary artery
Ao = aorta
TV = tricuspid valve
MV = mitral valve
º = Ectopic atrial
*** = Concealed Bypass Tract**
• = Wolff-Parkinson-White
n = AV Node Reentry

Results

Of these 14 patients, there were six with concealed bypass tract tachycardia, four with WPW, one with AV node reentry tachycardia (AVNRT), and one with the permanent form of junctional reciprocating tachycardia (PJRT). The remaining two patients had ectopic atrial tachycardias (Table 1).

In the six patients with concealed bypass tracts, the tachycardia was mapped to the right AV groove in two cases, the left AV groove in three patients and the mouth of the coronary sinus (CS) in the other patient. In the four patients with WPW, there was one pathway mapped to the left free wall and three mapped to the septal region. The PJRT, as well as the AVNRT, were mapped to the mouth of the CS. In the patients with ectopic atrial foci, the location was in the right atrial septum in one individual and left atrial septum in the other (Figure 1). Multiple pathways were seen in four of the patients.

Ablation attempts were divided into two categories based on the duration of energy applied. Short ablations were those lasting 30 seconds or less, and long ablations were classified as attempts of 31 - 60 seconds. The number of short ablations ranged from 0 - 94 (16.3 ± 23.4), and the number of ablations of greater than 30 seconds ranged from 1 - 17 (4.8 ± 4.3).

Overall, the procedure was successful in 14 of 17 of the patients (82%). In the four patients with manifest pathways (WPW), the success rate was 100%. Seven of eight patients with concealed pathways were also successfully ablated (88%), as were one of the two AVNRT cases, and the patient with PJRT. In addition, one of the two patients with automatic ectopic foci was also successfully ablated.

Complications experienced included transient airway obstruction in a 5-year-old that was overly sedated. This was easily relieved by repositioning the patient's head and neck. There has been no arterial or venous occlusion from the large sheaths.

During the follow-up period, which ranged from 6 - 37 months (m = 17.3), there have been two recurrences in patients considered to have had successful procedures. The first was a 6-year-old (Patient #13, Table 1), who experienced a recurrence of palpitations following the successful ablation of a right-sided concealed bypass tract. A follow-up electrophysiology study showed her to have AVNRT that was not noted at the time of her original study.

The second episode involved a young man with AVNRT that was very difficult to induce in the catherization lab (Table 1, Procedures 8,9). Following an attempted ablation, this patient continued to have evidence of dual AV node pathways, but no further tachycardia could be induced. He was discharged home on no medications, and approximately one month later there was a recurrence of his SVT. Follow-up catherization showed AVNRT that was easily induced and sustained. A repeat ablation was performed and he has been tachycardia free for 18 months.

Discussion

Supraventricular tachycardia (SVT) is not uncommon in the pediatric age group. The reported incidence is approximately 1 in 25,000 children (4).

There appears to be two peaks in the occurrence of SVT in pediatric patients. The first is in early infancy, usually within the first three months of life, and the second during adolescence. In a recent study by Perry and colleagues (5), it was found that 93% of patients that presented with WPW and SVT under 2 months of age, had no SVT at 8 months of age. Of those patients that had the tachycardia disappear, 31% had it reappear at a mean age of 8 years.

In those patients who have symptomatic tachycardia, the main therapy has been medical. Medications used in treating these arrhythmias range from digoxin (Lanoxin) and beta blockers such as Inderal, up to and including Type III antiarrhythmics (6). Medical management continues to be the primary modality for treatment in infants and children under 5 years of age. Occasionally, medical treatment will fail to give adequate control of the arrhythmia or the side effects of the medications are great enough to warrant their discontinuation. It is in this group of patients that non-pharmacologic methods of treatment need to be considered.

Until the early 1980s, the only alternative to medical management of arrhythmias was surgical. The success rate for surgical intervention ranges from 86%-99% (7-9), but there are the drawbacks of going through an open chest and possibly an open heart procedure. In 1982, Scheinman and colleagues (10) published their experiences in using closed-chest catheter ablation. This was followed by numerous reports on the use of this procedure (11-18).

In 1989, Bromberg et al (11) presented six patients, 8-15 years in age, that had direct current catheter ablation for treatment of SVT. In this initial report, 2 of the 6 remained tachycardia free for a follow-up period which ranged from 18 to 24 months.

In another study, Van Hare and colleagues (14) reported on the use of radiofrequency energy in the catheter ablation of 17 pediatric patients. Their results indicated the procedure was curative in 14 (82%) of these children with no significant complications, and suggested that RF energy may be safer than DC energy because there would be less barotraumatic complications (14).

Following these two initial reports, there have been numerous reports (15-18) published on the use of RF ablation in pediatric patients. The papers have looked at the use of RF ablation in infants and small children (15), ectopic atrial tachycardia (16), patients with coexisting congenital heart disease (17), and different catheter techniques for difficult pathway locations (18).

Conclusion

Based on the studies we have mentioned and our initial experience, we are presently performing RF ablation at WVU Children's Hospital on pediatric patients who have failed medical management.

Patient selection for RF ablation varies as follows according to age:

* In children under 1 year of age, RF ablation will be considered if the child continues to have life-threatening arrhythmias with the use of antiarrhythmic agents from all classes (6).
* In children 1 - 5 years of age, the patient should have failed medications from at least two classes of antiarrhythmics.
* In children who are older than 5 years of age, RF ablation will be considered if the patient has failed at least 1 antiarrhythmic agent, or has evidence of rapid conduction antegrade down an accessory pathway. A special circumstance in this age group would be in patients with a combination of SVT and complex congenital heart disease in which it is decided that the SVT should be addressed prior to or during surgical intervention.
* In the older adolescent and young adult, the previous criteria will be used with the addition of consideration for special circumstances such as participation in athletics or the military.

Using these criteria, we have performed 17 ablations in 14 patients. Our patient mix and overall success rate of 82% is very similar to that published to date (14).

In summary, the use of RF ablation in pediatric patients with arrhythmias that are life threatening or resistant to medical management is a safe and effective procedure that has the advantage of being curative without the morbidity of open chest procedures.

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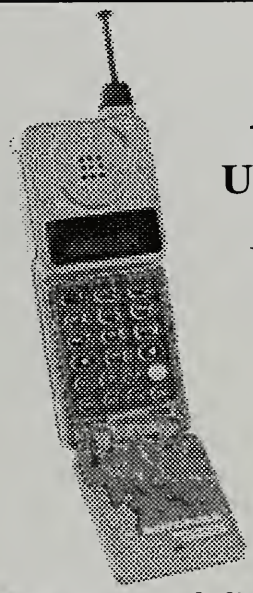

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At mother's mercy: The nightmare of Munchausen syndrome by proxy

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Abstract

Munchausen syndrome by proxy is a form of child abuse in which a parent simulates or produces illness in a child for the purpose of engaging in a supportive relationship with a physician or other health care provider. The child suffers from the parent's actions and is subjected to significant morbidity due to extensive medical diagnostic procedures ordered by the unsuspecting physician. The purpose of this paper is to provide a better understanding of this disorder with respect to presentation, pathogenesis, and recognition.

Introduction

Munchausen syndrome by proxy is a serious and potentially lethal form of child abuse in which a parent, usually the mother, deliberately simulates, fabricates, or causes physical symptoms in a child for the purpose of engaging in an intense but often destructive relationship with a physician or other health care provider (1,2).

In this sobering form of abusive behavior, the child not only suffers from the parent's actions, but is also subjected to significant morbidity and mortality due to extensive and painful medical procedures ordered by the perplexed treating physician who is unaware of the parent's deceptions. The paper is designed to provide a better understanding of this dangerous syndrome with respect to clinical presentation, pathogenesis, and recognition.

Historical note

The term "Munchausen syndrome" was first used by Asher in 1951 to describe adults who consistently fabricated symptoms of illness leading to numerous medical investigations, and was named after the 18th century Russian cavalry officer Baron Karl von Munchausen (3). Munchausen was known for his outrageous stories and his habit of wandering from town to town to find a new audience for them (4).

In 1977, Meadow coined the term "Munchausen syndrome by proxy" in his report of two cases in which mothers repeatedly caused their children to be ill (5).

Case study

A two-year-old white male was admitted because of fever, joint pain, and diarrhea. His fever and diarrhea resulted in an extensive investigation and ultimately a Broviac line was placed for central hyperalimentation. Bloody stools developed after an attempted feeding, and the bleeding persisted after discontinuation of the feedings.

An elaborate diagnostic endeavor, multiple transfusions, and four operations including transverse colostomy were then conducted. The resulting colostomy bag filled with blood shortly after surgery and the presumed offending segment, the right colon, was resected and an ileostomy created. This surgical specimen was examined pathologically found to be normal, but bright red blood soon began to appear in the ileostomy bag. Transfer to the ICU resulted in cessation of the bleeding, but on return to his room, the hemoglobin dropped to 6 gm with no apparent blood loss in the gastrointestinal tract or elsewhere.

When a nurse went to investigate a long stay in the bathroom by mother and child she discovered that blood was on the walls, the sink, and in the wastebasket, and the mother was found holding a syringe containing blood. The medical team surmised that the mother had been systematically removing blood from the Broviac line and producing the factitious bleeding and then the blood loss anemia (6).

Clinical presentations

The severity of Munchausen syndrome by proxy is quite variable, ranging from parents who only report false symptoms to the more extreme cases of parents directly causing physical harm or even death in the pursuit of making their children appear ill. Currently, there are over 185 papers in the pediatric literature describing children subjected to Munchausen syndrome by proxy (7).

The true prevalence of this syndrome remains unknown, although recent literature reviews suggest that this is not necessarily a rare disorder, and that many cases go undetected (8). A 1990 study of 127 apnea monitoring programs, for example, suggested a 0.27% incidence of infantile apnea which appeared to have been induced by a parent (9). In another study of 1,648 asthmatic patients in Belgium, 17 families (1%) were identified as having Munchausen syndrome by proxy (10). Many more cases of this syndrome will likely be diagnosed as physicians become increasingly aware of its presentations.

In 1987, Rosenberg (11) conducted an extensive literature review of all published reports of Munchausen syndrome by proxy, and found in nearly all instances the perpetrator was the mother. The mean age of the child at the time of diagnosis was 40 months, with an equal prevalence of male and female children involved.

Although the typical presentation was of multiple-system illness, the most common presenting complaint was bleeding which presented in 44% of the cases, followed by seizures in 42% of cases; central nervous system depression in 19% of cases; apnea in 15% of cases; and diarrhea, vomiting, fever, or rash, each presenting in about 10% of cases. Poisoning of the child by the mother to elicit physical symptoms was very common, such as giving warfarin to create bleeding; imipramine or phenothiazines to elicit seizures; and insulin, barbiturates, or chloral hydrate to cause CNS depression.

Manual suffocation was a prevalent method to produce apnea. Other tactics used by the mothers to create symptoms of illness included applying exogenous blood to the child, strangulation, lying about symptoms, falsifying temperature, scratching the child, and painting the child's skin.

The mothers involved in these cases have many similar characteristics. A significant number have prior training

and work experiences as either nurses, medical receptionists, or other health care professionals (12). Surprisingly, most of the mothers are considered ideal parents during their interactions with medical staff. They tend to develop close relationships with the nurses and doctors they come in contact with and often pursue social contact with these medical personnel outside of the hospital.

These mothers are observed to be extremely attentive to their children and assume responsibilities that would typically be those of hospital staff. When unaware of being observed, however, they display indifference towards their children, and even at times exhibit pleasure in the midst of clinical catastrophes involving their children (7).

Pathogenesis

Munchausen syndrome by proxy can best be understood in terms of the mother's need for a relationship with a parental figure, in most cases a physician, that is rooted in a profound sense of early abandonment (13). These mothers often have experienced abuse in their own childhoods, and typically their sense of rejection continues into adult life through poor marital relationships. The child serves as little more than an object to regulate and continue the relationship between herself and the physician (2).

Through the relationship created with the physician, the mother feels valued and listened to by a powerful parental figure. She is therefore able to establish an increased sense of self-worth and importance which relieves her previous feelings of hopelessness and isolation (7). As would be expected, these mothers possess a great deal of psychiatric psychopathology, notably histrionic and borderline personality disorders, and depression (14).

Physicians play an unwitting but integral role in the dynamics of this syndrome. Trained to exhibit competence in solving even the most difficult clinical problems, physicians often adopt a feeling of personal failure in these cases as they are repeatedly unable to resolve these children's confusing symptoms. Such feelings of guilt generally lead to persistent efforts to work even harder on the unsolvable medical dilemma. Ironically, 75% of the morbidity in published cases of Munchausen syndrome by proxy took place at the hands of doctors, rather than the mothers (11).

Recognition

Munchausen syndrome by proxy resembles the struggles often enacted between the parents of chronically ill children and their doctors (7). Accordingly, diagnosing this syndrome is often an arduous and time-consuming task.

The warning signs (12) that should alert the physician to the possibility of Munchausen syndrome by proxy are as follows:

1. Recurrent illness that cannot be explained.
2. Discrepancies between the history, clinical findings, and general health of the child.
3. Working diagnosis is a rare or obscure disorder.
4. Symptoms only occur in the presence of the mother.
5. A mother who is extremely attentive and is always in the hospital.
6. A child who is frequently intolerant to treatments.
7. A mother who appears less worried about the health of her child than is the medical staff.
8. Seizures refractory to appropriate treatment.
9. Families in which sudden unexplained infant death has occurred.
10. A mother with previous experience working in a health care field.

If Munchausen syndrome by proxy is suspected, appropriate investigatory steps must be taken immediately. These include a detailed review of the medical history with verification from family members other than the mother; distinguishing complaints that occurred when only the mother was present from those witnessed by others; and if there is no other recourse, video surveillance of the mother and the child in the hospital. The most useful tool, however, has often proven to be isolation of the child from the parent. The resolution of symptoms in parental absence is a consistent finding in fabricated cases and can be the key to diagnosis (15).

Once the diagnosis has been established, the mother should be confronted by the treating physician to explain that he/she knows that she is harming her child. She should be informed of the necessary legal steps that will be taken to protect her child, and of the availability of psychiatric help for her and her family. At this stage, most mothers will consistently, convincingly and calmly deny such acts of abuse and fabrication, even when presented with compelling evidence. The intervention must focus on ensuring the safety of the child regardless of the mother's response (16).

Conclusion

Munchausen syndrome by proxy is a form of child abuse in which a parent simulates or produces illness in a child. Case reports of this dangerous syndrome document a wide and confusing spectrum of symptoms.

The children who are victims of this syndrome suffer significant risks of morbidity and mortality. Due to these extreme consequences, all health-care professionals should be able to recognize its warning signals.

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Three cases of hemorrhagic colitis in West Virginia due to *Escherichia coli 0157:H7*

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Abstract

Escherichia coli 0157:H7 is an emerging cause of food-borne illness. This bacterial pathogen, most commonly transmitted by undercooked ground beef, causes hemorrhagic colitis. It has been associated with the hemolytic uremic syndrome and death, mostly in children and the elderly. This article describes three patients treated for sporadic cases of Escherichia coli 0157:H7-associated hemorrhagic colitis at Charleston Area Medical Center over a three-week period.

Introduction

Escherichia coli 0157:H7 was first recognized as a human pathogen during an outbreak of bloody diarrhea in Michigan and Oregon in 1982 (1). It has since been implicated in numerous outbreaks of hemorrhagic colitis, mostly in nursing homes and day care centers (2-6). Community outbreaks have also been reported (1,7-9), and sporadic cases are not uncommon (10-12).

Contaminated ground beef is the most common vehicle of transmission, although other sources such as unpasteurized milk have been implicated (1,7,9). Person-to-person transmission occurs via the fecal-oral route (3). Recently, a contaminated lake near Portland, Ore., was the source of a major outbreak (13).

Most cases of this bacterial pathogen have occurred in the northern U.S. and Canada. Last year, we documented three cases of *Escherichia coli 0157:H7* at Charleston Area Medical Center (CAMC) over a three-week period.

First case

A 37-year-old white female was brought to CAMC with abdominal pain, nausea and vomiting. She also had been having up to 20 loose, bloody stools a day for four days.

This patient lived in a rural area and had well water. No one else in her family was ill, and she denied any recent travel or antibiotic exposure. Her other medical history was unremarkable except for the fact that she frequently ate at fast food restaurants.

Examination revealed a temperature of 37.0 C and a pulse of 108 beats per minute. Her abdomen was soft with hyperactive bowel sounds, and diffusely tender without rebound or guarding. Rectal examination revealed bloody stool. Abnormal laboratory values showed a white blood cell count of 17.9 K/CU M with 72% neutrophils, 2% bands, 20% lymphocytes, and 5% monocytes; hemoglobin was 16.4 gm/dl.

Abdominal films showed a non-specific gas pattern. Stool examination revealed leukocytes. Studies for standard enteric pathogens (*Salmonella, Shigella, Campylobacter,* and *Yersinia*), and ova and parasites were negative. Stool testing for *Clostridium difficile* toxin was positive, despite no recent antibiotic use. An *Escherichia coli,* presumptive *0157:H7,* was first isolated on MacConkey-sorbitol agar, then identified by latex agglutination techniques and confirmed by the state laboratory.

She was treated with intravenous ciprofloxacin, plus oral vancomycin for the *C. difficile.* Leukocytosis returned to the normal range and she remained afebrile. Bloody stools slowly decreased in frequency and she was discharged after six days.

Second case

A 16-year-old white male presented to the hospital with severe crampy abdominal pain, nausea, and profuse small volume bloody diarrheal stools for two days. One day prior to admission, this patient had undergone outpatient flexible sigmoidoscopy which revealed only non-specific mucosal changes. Stool samples were obtained for culture at that time.

He had undergone extraction of his wisdom teeth four days before the onset of symptoms, and he had been taking penicillin four times daily since his surgery. He reported drinking several milkshakes from various fast food restaurants since the oral surgery, but denied the intake of any hamburgers. He and his family had been camping in West Virginia 10 days prior to his symptoms, but they did not drink spring or well water.

Physical exam revealed an alert, ill-appearing adolescent male. He was afebrile at 36.3 C, with normal vital signs. The abdomen was soft, with normoactive bowel sounds, and moderately severe diffuse abdominal tenderness without rebound or guarding. Stool was grossly bloody. Laboratory values indicated a white blood cell count of 19.3 K/CUM with 80% neutrophils, 2% bands, 7% lymphocytes, and 11% monocytes; hemoglobin was 16.8 gm/dl. Stool samples from the outpatient sigmoidoscopy revealed presumptive *E. coli 0157:H7* which was later confirmed by the state laboratory. Stool was also positive for *C. difficile* toxin, but studies for enteric pathogens, ova and parasites were negative.

He was treated with intravenous ceftriaxone, as well as oral metronidazole for the *C. difficile.* A repeat stool sample tested for *C. difficile* toxin was also positive. His stools slowly decreased in frequency, and became non-bloody on the fifth day of his hospitalization. His temperature remained less than 38 C and the leukocytosis resolved.

He was discharged home on the fifth hospital day.

Third case

A 66-year-old white female from Chicago presented to the hospital suffering from two days of bloody diarrhea. She had driven from Chicago to the Charleston area to visit relatives three days before admission to the hospital. She did not eat at any fast food restaurants or consume any ground beef along the way. Upon arrival in Charleston, she did eat hamburgers made from ground beef from a local grocery store.

Her 16-year-old granddaughter in Chicago had been hospitalized for similar symptoms several days prior to the patient's departure for West Virginia. She had brief physical contact with her granddaughter one day before leaving the Chicago area. It was later reported that her granddaughter was infected with a hemorrhagic *E. coli.*

This patient was ill-appearing but alert, had normal vital signs, and a temperature of 36.7 C. Abdominal exam was remarkable for hyperactive bowel sounds and diffuse tenderness without rebound or guarding. Rectal exam revealed bloody stool. Abnormal laboratory values indicated her white blood cell count was 11,600 K/CU M with 81% neutrophils, 2% bands, 12% lymphocytes, and 3% monocytes. Fecal leukocytes were present, but stool studies for standard enteric pathogens as well as ova and parasites were negative. A presumptive *E. coli 0157:H7* was identified in a stool sample and was later confirmed at the state laboratory. Her condition improved with intravenous hydration and oral ciprofloxacin. Her stools decreased in frequency and became non-bloody on day five of her illness, and the diarrhea resolved completely after seven days.

The ground beef from the local grocery store, consumed one day before the onset of symptoms, was tested by the state laboratory for *E. coli 0157:H7*. Those results were negative.

Discussion

No common source of infection was identified for these three patients. All cases occurred during the month of August, consistent with previous reports that the incidence of infection peaks in the summer months, usually July and August (12).

It is interesting that two of our three cases also had stool samples positive for the *Clostridium difficile* toxin. One had been on antibiotics. It is not clear whether this was a true positive result. Both of these cases were treated for presumptive pseudomembranous colitis because they were severely ill. Baxter Diagnostics, the maker of Bartels *Clostridium difficile* Enzyme Immunoassay kit used by CAMC, reported that in their lab studies there has been no cross-reactivity between *E. coli 0157:H7* and their EIA kit.

E. coli 0157:H7, which produces a Shiga-like cytotoxin, can cause asymptomatic infection, mild non-bloody diarrhea, hemorrhagic colitis, hemolytic uremic syndrome, thrombotic thrombocytopenic purpura, and death (4,6,9,14,16). It has been mistaken for ischemic colitis in the elderly, and for inflammatory bowel disease (15). Patients at the extremes of age are at greatest risk for developing hemolytic uremic syndrome (HUS) in association with this infection (2,9,14). HUS will occur in 2%-7% of cases, is a common cause of renal failure in children, and has a case-fatality rate of 3%-5% (9,14).

Thrombotic thrombocytopenic purpura (TTP) associated with this strain of *E. coli* has been reported in adults (16). None of our patients showed signs of HUS or TTP.

The use of antibiotics in this illness is controversial. In one study, patients treated with antibiotics had a higher fatality rate than those not treated (2). However, only the sickest patients received antibiotic therapy (2). In another study, patients treated with trimethoprim-sulfamethoxazole were more likely to develop HUS (6). To date, there have been no studies demonstrating the efficacy of antimicrobial therapy.

Studies have not shown that antibiotics shorten the duration of illness (5). It has been suggested that agents which decrease intestinal motility should be avoided altogether since this may allow multiplication of the organism and increased production of the Shiga-like toxin (5).

Sporadic cases of hemorrhagic colitis due to *E. coli 0157:H7* occur in West Virginia. Infection with this pathogen is becoming a reportable infectious disease in our state due to the recognition of these cases. We hope this article will help clinicians become more aware of this important pathogen and the wide spectrum of disease that it causes.

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Response to treatment with progesterone in a patient with pulmonary lymphangioleiomyomatosis

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Abstract

Lymphangioleiomyomatosis (LAM) is defined as an abnormal proliferation of smooth muscles around lymphatics, venules, and brochioles. This article describes our experiences treating a 21-year-old, white female who experienced recurrent shortness of breath during air travel last year. Her episode was severe and the patient was transported to the hospital as soon as the airplane landed. Physical exam in the emergency room was significant for absent breath sounds on the right side and the chest X-ray revealed a pneumothorax. She required two chest tubes for complete lung re-expansion. Further evaluation showed an obstructive pattern and air trapping on pulmonary function tests. This patient was treated with Medroxyprogesterone acetate (MPA) for six months and subsequent pulmonary function tests revealed improvement in her condition.

Introduction

Pulmonary LAM is a rare disease that results from the proliferation of immature smooth muscle throughout the tissue surrounding the bronchi, blood vessels, and lymphatic vessels (1). The first case was reported by von Stossel in 1937 and called muscular cirrhosis of the lungs. It was initially recognized as a syndrome in 1942 by Rosendal (2).

It is believed that any patient with renal angiomyolipoma and pulmonary problems should be evaluated for pulmonary LAM. A study performed at Mayo Clinic of 27 patients with LAM showed that seven of them had coexisting renal angiomyolipoma (5).

The usual presentation of pulmonary LAM includes dyspnea, cough, chest pain, hemoptysis, pneumothorax, and/or chylothorax. Most of the patients do not survive more than 10 years from the time of the initial presentation (2,4).

The most common findings on pulmonary function tests are obstructive or combined obstructive and restrictive pattern. A CT scan of the chest usually demonstrates bilateral lung cysts and/or ground glass opacities. Open lung biopsies reveal either a predominantly cystic type of lesion or a predominantly muscular type (2,4).

LAM usually affects women in their childbearing age and has been observed to be rapidly progressive during pregnancy. This observation suggests therapeutic opportunity through sex hormonal manipulation (1). Treatment modalities include Medroxyprogesterone acetate, Tamoxifen, and oophorectomy.

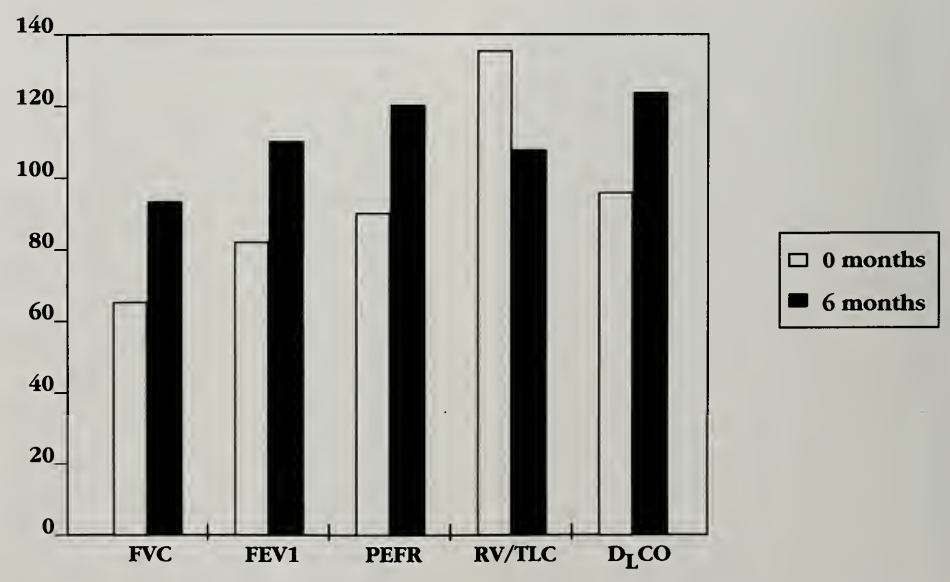
The patient we report on in this article showed improvement after six months of treatment with progesterone.

Case Report

A 21-year-old, white female, developed shortness of breath while flying from Florida to Ohio on July 10, 1994. She was a college student in Wheeling, W.Va., who was told by her family doctor that her shortness of breath was secondary to heat exhaustion.

Table 1. Pulmonary Function Studies

Index	Time After Therapy		% Change
	0 months	6 months	
FVC (litres)	2.72 (68%)	3.79 (95%)	+27
FEV1 (litres)	2.68 (83%)	3.52 (109%)	+26
PEFR (litres/sec)	6.05 (93%)	7.80 (120%)	+27
RV/TLC	134%	111%	-23
D_LCO	21.30 (97%)	27.70 (126%)	+29



Two days later, this patient developed another episode of shortness of breath with chest pain while flying from Ohio to Colorado on July 12. She was transported immediately to the University of Colorado Hospital in Denver, where a chest X-ray in the Emergency Room revealed a 100% pneumothorax on the right side.

The placement of two chest tubes at the hospital allowed for complete lung re-expansion. This patient was taking no medications except for oral contraceptives and her past surgical history was significant only for left nephrectomy secondary to angiomyolipoma the prior year.

She was discharged from the hospital on July 24, and was advised to see a pulmonologist for further evaluation. A chest CT scan three days later showed small cystic lesions with thin walls scattered in both lungs. These findings were suggestive of LAM. The patient then underwent pulmonary function tests the following day which showed obstructive pattern with air trapping (Table 1, 0 months).

This patient was started on an injection of Medroxyprogesterone acetate (MPA) 400 mg IM every month. Six months later, the pulmonary function tests were repeated (Table 1, 6 months), and they demonstrated improvement in her condition.

Discussion

LAM is a rare pulmonary disease of which the etiology is unknown. It is a condition that affects only women who are usually always in their reproductive years. The disease progresses and leads to death from respiratory failure usually within 10 years (3).

Due to the rarity of the disease, there have been no randomized trials to compare regimens of treatment, but Taylor and colleagues recently reviewed the clinical response in 32 patients with LAM. Of the 19 patients treated with medroyprogesterone acetate (MPA), two improved, six remained stable, and 11 patients deteriorated. Nine of the patients were treated with tamoxifen and none of them improved; six worsened. They concluded that MPA should be the first line of therapy and oophorectomy, therefore, should be the second line of treatment. They suggested that tamoxifen provides no benefit and should not be used in the line of therapy.

After treatment with Provera for six months, our patient was clinically stable and showed improvement in her pulmonary function tests (Table 1, 6 months). Currently, she is still receiving Provera. In addition, she is also being followed every six months with pulmonary function tests and yearly with a chest CT scan.

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Manuscript Guidelines

All scientific manuscripts should be submitted on an IBM compatible disc in Wordperfect 5.1 or in ASCII (generic). They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced on white bond paper, and have the page numbers printed in the right-hand corner of each page.

All manuscripts should include:

1. Title page
2. An abstract of no more than 150 words
3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively. No more than 25 references will be published free of charge.
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

Cortical blindness following cerebral angiography

JAMES D. HELSLEY, M.D.
Associate Professor, Robert C. Byrd Health Sciences Center of West Virginia University, Department of Family Medicine, Morgantown

Abstract

The use of radiological contrast agents is a common and necessary part of clinical medicine. Side effects of these agents are usually categorized as either allergic reaction including anaphylaxis, or specific organ system insult (i.e. renal impairment). A rare, but reported effect of vascular radiological contrast is transient cortical blindness.

Case report

A 57-year-old female developed nausea and moderate general headache after undergoing extraction of a molar for periodontal disease. Suddenly, two days after her extraction, she had to be brought to Ruby Memorial Hospital because she had developed a severe bi-occipital and retro-orbital headache associated with photophobia, nausea and vomiting. She described the headache as the worst since the self-limited era of migraines in her 20s.

This patient was alert with a temperature of 37C, BP of 122/76 mmHg and her pulse was 96/min and regular. HEENT exam confirmed the recent molar extraction site and was otherwise normal. The neck was supple and free from specific findings. Neurologic exam was negative, and deep tendon and plantar reflexes were normal. Uncorrected vision was 20/100 bilaterally.

Lab studies revealed a WBC of 16,800/c.mm, Hct of 49.7%, glucose of 327 mg/dl; her electrolytes were normal and BUN was 10mg/dl. Initial CT scan of the head was normal with the exception of an incidental subdural frontal hygroma. Lumbar puncture showed an opening pressure of 70 mmHg; protein 46 mg/dl and glucose 155 mg/dl. Microscopic examination of the cerebro-spinal fluid (CSF) revealed one RBC and one WBC. Gram stain and India ink preparation were negative, as was the subsequent bacterial culture.

This patient was admitted and given IV hydration, promethazine and mild narcotic analgesia. The glucose was controlled by sliding scale doses of insulin. After 18 hours, her symptoms were only marginally improved, so a cerebral arteriogram was performed with 150cc Conray 60 (Mallinckrodt) to investigate the possibility of an undiagnosed lesion.

She tolerated the procedure well, but upon return to her room, developed complete blindness. She remained awake, oriented, cooperative and quite stable. Hysterical reaction was ruled out by the absence of nystagmus in response to use of the opti-kinetic drum. The ophthalmologic exam revealed no causes for direct ocular-related blindness, so another unenhanced CT scan was ordered. It revealed no changes from the CT scan at admission.

This patient received IV bolus fluid, nimodipine, and IV dexamethasone, with continued supportive care. After 24 hours, she reported seeing a faint indication of light upon bright light challenge. By 48 hours after the normal arteriogram, she reported complete return of sight, including color vision, hampered only by impaired acuity from hyperglycemia. Other measures were discontinued and she was discharged with appropriate diabetic management.

Discussion

There are reports of cortical blindness associated with the use of radiological contrast media in cerebral, carotid, aortic, and coronary angiography. The development of this condition has been associated with several different agents such as Renografin 60, Hypaque M60 and Omnipaque (Winthrop); Conray 60 (Mallinckrodt); and Angiovist 370 (Berlex). No correlation can be drawn between the type of contrast medium or the amount injected in the cases reported.

The cause of contrast-induced cortical blindness has not been established, and the role of vasospasm is unproven. It is generally considered that alteration of the blood-brain barrier (BBB) over the ocular cortex is the cause of the insult that leads to blindness. The BBB consists of a cerebral capillary endothelium, composed of tightly-connected cells, and a continuous basement membrane underneath, so it is relatively impermeable compared to the capillary structure in non-neural tissues. This serves to explain the properties of selective filtration of the BBB.

In general, water soluble substances, i.e. radiological contrast material, do not pass through the lipid oriented BBB. Contrast media are thought to produce an alteration in the BBB, which allows passage of the media into direct contact with the cerebral spinal fluid and cortical cells. In the case of the ocular cortex, the net clinical effect is diffuse, uniform and usually total blindness.

Hyperosmolality of the contrast media is felt to be a cause of impaired endothelial integrity, but other theories exist. Changes in vasodilation, increased vascular transport, and transient focal anoxia from red cell aggregation are all postulates; however, general agreement is in favor of the hyperosmolality concept.

Once the offending agent has cleared the cerebral circulation, the BBB resumes its selective filtration. The ocular cortex recovers from the contrast insult and vision returns in usually 1-2 days. Clearance of the contrast material from the brain tissue is not understood. It is not clear whether the material re-enters the arterial circulation through an open BBB, passes into the venous circulation via the CSF, or is actively transported out of the CSF.

Transient cortical blindness following contrast infusion into the cerebral circulation may occur in up to 1% of cases, and no specific therapy has been confirmed as worthwhile. Theoretically, corticosteroids such as dexamethasone might stabilize the BBB; however, its value in this setting is not proven. Fortunately, vision is usually restored within two days. Initially, the patient recovers some light and motion vision, then proceeds to regain full sight including color. No long-term sequelae have been reported.

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President's Page

The only constant is change

Editor's Note: As is customary for the last issue of the year, the president of the WVSMA Alliance is given this page to present a special message.

It is not by mere coincidence that the headline I have chosen for my message is the same as Dr. Helsley's title for his inaugural address. The WVSMA and the Alliance are unified to form a strong voice for common concerns. Therefore, it is quite appropriate that our thoughts should be closely aligned with one another. The practice of medicine has changed dramatically over the years and the Alliance has changed to reflect those images.

There was a time when the spouses of physicians were mainly known for having tea parties and wearing hats. This image has vanished much the same as the image of the patient directly paying the physician. Today, we are activists who are involved in a variety of endeavors to make positive changes for the health and well-being of others, and work to protect medicine from harmful changes. Adaptation to the environment promotes the continuation of a species. We can adapt and we will, but we will also attempt to effect the environment to benefit all.

We have become a Medical Family instead of separate beings -- not just physician, spouse, and child alone. Since every member of the family is affected by the changes in medicine, we must all be involved to enact the best changes for our family. The WVSMA Alliance provides the avenue for us to work together as a TEAM.

In order to emphasize the importance of the interaction between the WVSMA and the Alliance, along with the effort by each entity, I have chosen TEAM -- "Together Everyone Accomplishes More," as my theme for the year. We truly do accomplish more as a TEAM. There is great strength in numbers. Every action we take on the county or state level is heard three times since there is an impact at the county, state and national level. Together our voice is heard loud and clear.

Our health focus this year originates from the AMA and AMA Alliance as *SAVE -- "Stop America's Violence Everywhere."* In West Virginia we are focusing on adolescents, striving to provide a more nurturing environment for our children. In January, we will be introducing a bill that will make it mandatory for all audio materials to have a rating label attached. This bill also contains a law which makes it a criminal act to sell to those protected by the label rating. Currently, there are no legal protections prohibiting minors from purchasing or watching a PG, PG-13, PG-17, or even R-rated items.

In addition, we have recently had approval from the West Virginia Board of Education for a curriculum by Dr. Prithrow-Stilth concerning conflict resolution. This program provides a video for the teachers to demonstrate how to administer the curriculum for their students. It will be available to every component alliance, whose members can then take it into their county schools.

I am also very pleased to announce that a video has just been completed entitled *"The WVSMA/Alliance 1996 Legislative Update,"* which features Dr. Thomas Sporck, chairman of the WVSMA Legislative Committee, Nancy Kessel, chairman of the WVSMAA Legislative Committee, and Dr. Helsley and myself. These videos have been mailed to every component society and alliance. Be sure to use them.

Since political awareness is so critical to the practice of medicine, I hope all WVSMAA members will try to attend the special Legislative Briefings which will be conducted at the State Capitol on January 25, February 14 and February 29. In conjunction with the Legislative Briefing on February 14 (Valentine's Day), the Legislative Reception is also scheduled, so please bring your loved one to Charleston to participate in these special events. It is essential that as many physicians and Alliance members as possible attend so every legislative district in the state is represented. For more information, contact Winnie Morano at (304) 925-0342. In addition, the Alliance members are prepared to quickly provide the WVSMA members with critical information about state and national happenings pertaining to medicine with the Phone Bank, which can be put into operation at anytime.

No, we are not having tea parties, wearing hats and white gloves, unless it is to raise funds for a worthy cause such as the AMA Education and Research Fund for medical schools across the nation. We are not just a women's organization anymore because many male spouses have joined our ranks who share our same concerns for physicians, children and Medicine. Yes, we are adapting.

I appreciate the opportunity to share my views with you. I hope that you can see that you need us as much as we need you.

Linda Elliott
WVSMAA President

Time to stand up

In a speech at the recent annual meeting of the American Public Health Association, Dr. C. Everett Koop, former Surgeon General, endeavored to make common cause with American Medicine by stating that the climate in Washington is "downright hostile to health" and suggesting that the situation will not change until doctors and public health workers "stand up for our professions, not ourselves."

In his speech, Dr. Koop made the telling comment "The economics of managed care seems to be taking over from the ethics of managed care." We couldn't agree more. Dr. Koop went on, however, to blame the problem on the neglect of "the appalling prevalence of poverty." We're not sure we can go along with the latter statement since it implies endorsement of a return to burgeoning government poverty programs, the real basis of "the abrogation of personal responsibility," an evil appropriately noted by Dr. Koop in another passage.

The agendas of American Medicine and the American Public Health Association occasionally coincide but, for the most part, this phenomenon occurs rarely. As the "public" in the latter organization's name implies, its members, like those in any other organization with "public" in its title, generally have as their starting point a concern for centralized control of potentially large problems that might affect large masses or groups of public citizens. American Medicine has traditionally had as its focus concern for individual patients.

This difference constitutes the core of the longstanding struggle between American Medicine and any other individual, group, movement, plan or concept advocating a unified, homogeneous, mass approach to the organization and provision of medical care in this country. Public health measures are invaluable in the maintenance of general health, but simply cannot be put on an individual basis. The facts of these differing aims and solutions to human disease have been recognized on both sides, and respect along with a vigilant and wary kind of truce is ordinarily maintained by the potential combatants.

We think that directing our attention to "poverty," employing recent tradition, is unlikely to do anything beneficial for poverty or health care. The Republican Congress seems to have taken a long-term approach to the economy and to the general welfare by directing its efforts toward getting government out of our lives as much as possible, and in the process, balancing the budget.

We generally agree with this approach even though Medicine will take some serious hits in the process. In the long or short term, however, Medicine will lose none of its desirability and usefulness for the general public. With unrestrained government intrusion and looming fiscal bankruptcy, poverty can be made universal and in the process Public Health and Medicine will wither.

As Dr. Koop suggests, it is indeed time to, "stand up for our professions, not ourselves." For physicians, this means directing our attention to the potential government has for injuring our profession. Once this can be fully appreciated, our direction as a profession can be no longer in doubt. We shall continue our tradition of rejecting mass approaches to dealing with human disease and suffering, and keep our focus on individual patients.

Stephen D. Ward, M.D.
Editor

Dr. Lonnie Bristow Speaks To America's Patients About Medicare Reform:

I'm a practicing physician and I want my patients to know that Medicare will go broke by 2002 unless it's fixed now. The AMA has been working 10 years on ways to improve Medicare. Now Congress is about to act, and you need the straight story about what is really going on. Here are answers to questions patients ask me the most about the Medicare mess.

1. Does anyone have an answer?

The House Leadership has a plan that makes sense, tackles the hard financing problem and is good for patients. Most important, spending per person will *still* rise from $4,800 to $6,700 in 2002.

2. Will I have to give up what Medicare already gives me?

No. You can keep the security of traditional Medicare if you want. You won't have to do anything different.

3. Can I choose my own doctor and my own health plan?

Yes. In fact, patients will have more choices, including traditional Medicare, private insurance plans or a tax-free medical savings account.

4. How much more will it cost me?

You will pay a little more, but not a lot more. On average, monthly premiums will rise only $6 a year over the next seven years. If you choose a private sector health plan, there may be expanded benefits and lower out-of-pocket expenses.

5. Will patients be protected?

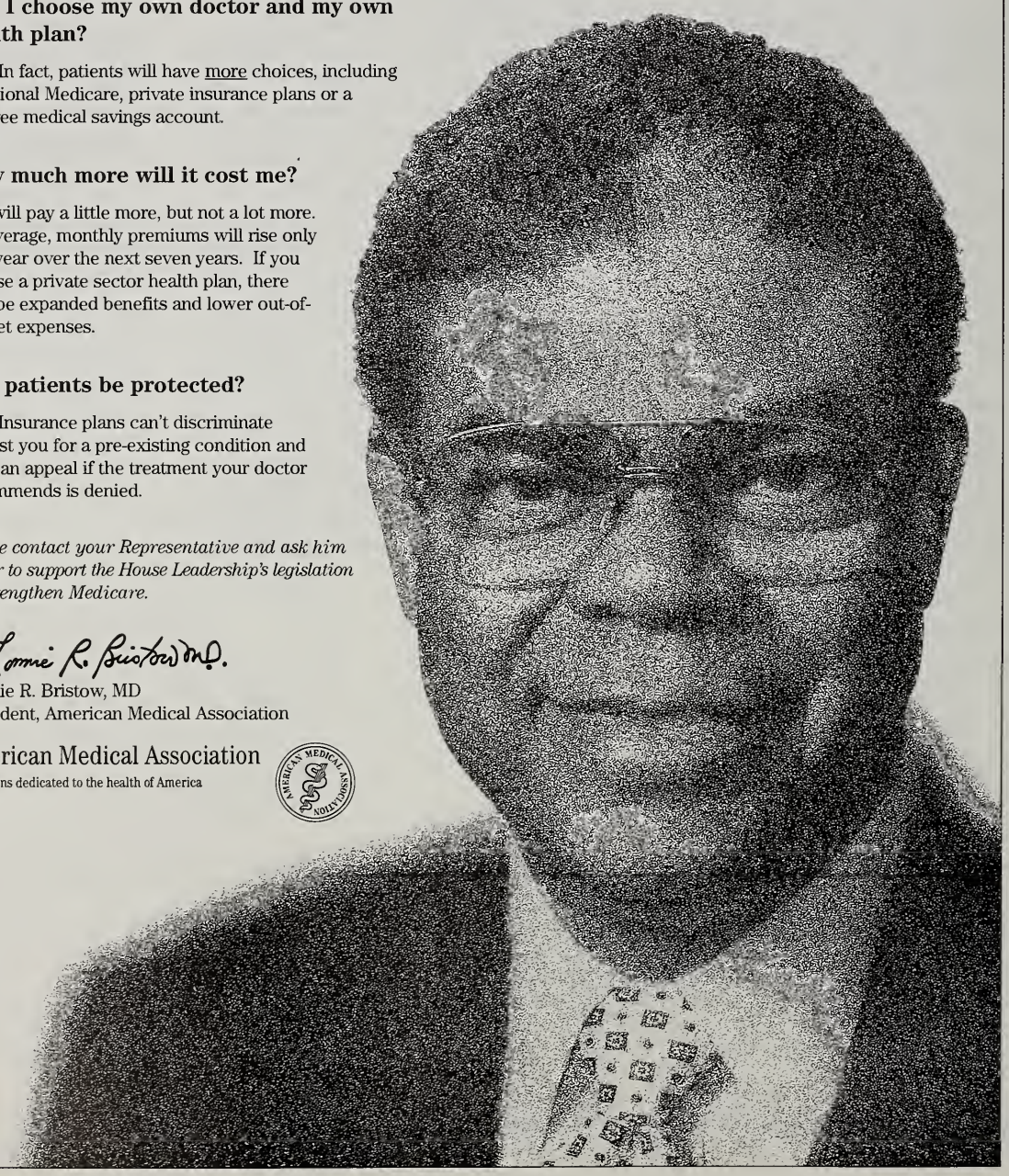
Yes. Insurance plans can't discriminate against you for a pre-existing condition and you can appeal if the treatment your doctor recommends is denied.

Please contact your Representative and ask him or her to support the House Leadership's legislation to strengthen Medicare.

Lonnie R. Bristow M.D.

Lonnie R. Bristow, MD
President, American Medical Association

American Medical Association
Physicians dedicated to the health of America



Mark these dates!

Legislative visits at the Capitol

January 25, 1996
February 14, 1996 - *Legislative Reception*
February 29, 1996

On all three occasions we will meet at 9:30 a.m. at the WVSMA office, for a brief update before leaving for the capitol. A shuttle bus runs all day to and from the parking area and capitol. (Directions will be given out at the WVSMA office). On February 14, the annual Legislative Reception will be at the Marriott that evening at 5:30 p.m. For more information about the Legislative visits or Reception, please call 1-800-257-4747.

Please plan to come!

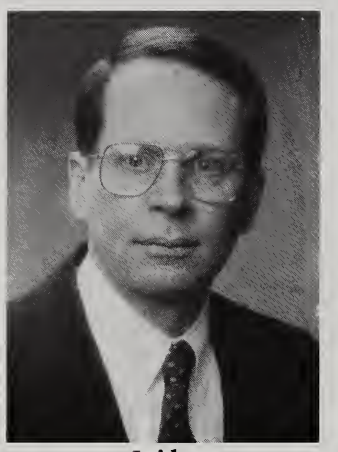
At Mid-Winter

Clinical challenges of internal medicine focus of lectures for First Scientific Session

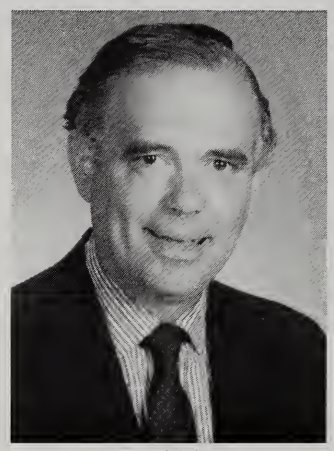
"Internal Medicine: Clinical Challenges in the '90s" is the title of the First Scientific Session which is set for Friday, January 19 at 1:30 p.m. during the WVSMA/WVACP's 1996 Mid-Winter Seminars and Scientific Conferences in Charleston at the Charleston House - Holiday Inn.

Guest speakers for this session are **John W. Leidy Jr., M.D.**, professor of medicine, pharmacology and physiology at the Marshall University School of Medicine, who will discuss *"New Agents in the Treatment of Diabetes;"* **Robert Hoeldtke, M.D., Ph.D.**, professor of medicine at the West Virginia University School of Medicine, who will lecture on *"Orthostatic Hypotension: Etiologies and Treatment;"* and **Jack Hirsh, M.D.**, director of the Hamilton Civic Hospitals Research Centre in Hamilton, Ontario, on *"New Concepts in the Treatment of Thromboembolic Disease."*

Brief biographical information about these physicians begins below, and more details about this year's meeting can be obtained by phoning the WVSMA at (304) 925-0342.



Leidy



Hoeldtke

Hirsh

Speakers highlighted

Dr. Leidy received both his M.D. and his Ph.D. in physiology and biophysics from the University of Washington in Seattle in 1979. Following an internship in medicine at Albert Einstein Medical Center in Philadelphia, Dr. Leidy remained in that city for a residency in internal medicine at the Medical College of Pennsylvania.

In 1982, Dr. Leidy moved to Denver to serve as a fellow in endocrinology and metabolism at the University of Colorado Health Sciences Center, where he was also appointed to the faculty as a clinical instructor in 1985. After completing his fellowship and teaching for a year, Dr. Leidy accepted a post at Marshall University as an assistant professor of medicine, where three years later he was also named an assistant professor of physiology.

In 1990, Dr. Leidy was promoted to an associate professsor of medicine and physiology at Marshall, and was named Clinical Instructor of the Year. This year, Dr. Leidy assumed his current roles as a full professor of medicine, pharmacology, and physiology.

A diplomate of the National Board of Medical Examiners, the American Board of Internal Medicine and the Subspecialty of Endocrinology and Metabolism, Dr. Leidy is also a fellow of the American College of Physicians. He currently serves as the medical school representative for the American Federation of Clinical Research and as medical advisor to the Tri-State Diabetes Association.

Dr. Hoeldtke received his M.D. degree from Cornell Medical School in 1966, and then completed a medical internship at Presbyterian St. Luke's Hospital in Chicago. After his internship, Dr. Hoeldtke became the senior assistant surgeon at the U.S. Public Health Service Hospital for Narcotic Addiction in Lexington, Ky., where the next year he was named a research associate.

In 1969, Dr. Hoeldtke began graduate studies at MIT, where he obtained a Ph.D. degree in 1972 in nutritional biochemistry. After receiving his degree, Dr. Hoeldtke was named a senior staff fellow at NIMH in Bethesda, Md., for two years, and then moved to Ann Arbor, Mich., to complete a two-year residency in medicine and fellowship in endocrinology and metabolism at the University of Michigan.

Dr. Hoeldtke's career then took him to Philadelphia, where he joined the faculty at the General Clinical Research Center at Temple University as a clinical associate physician in 1979. The next year, he became assistant program director of the center, and in 1984, he assumed another role at Temple as an associate professor of medicine.

After 11 years at Temple, Dr. Hoeldtke moved to West Virginia in 1990 to accepted his current post as the C. E. Compton Professor of Nutrition at the WVU School of Medicine in Morgantown. This year, he was named the Clinician of the Year by the West Virginia Affiliate of the American Diabetes Association.

Dr. Hirsh received both his M.B.B.S. and M.D. degrees from the University of Melbourne Medical School. After completing his M.D. in 1962, he became an assistant hematologist at Royal Melbourne Hospital in Victoria, Australia.

In 1964, Dr. Hirsh moved to the U.S. to become a research fellow in the Department of Internal Medicine at Washington University in St. Louis. The following year, he continued his

postgraduate studies in London as a research assistant in the Department of Hematology at Postgraduate Medical School, and became a visiting research scientist at the University of Toronto in Ontario, Canada.

In 1966, Dr. Hirsh returned to Australia to serve as the senior lecturer for the Department of Medicine at the University of Melbourne for four years. His career then took him back to Canada, where he joined the faculty of McMaster University in Hamilton, Ontario, as an associate professor in the Departments of Pathology and Medicine.

After a year, Dr. Hirsh was promoted to full professor and he held this post until 1981, when he was named professor and chairman of the Department of Medicine at McMaster. In 1988, Dr. Hirsh accepted his current post as director of Hamilton Civic Hospitals Research Centre and continued teaching on the McMaster faculty as a professor of medicine, where he is now professor emeritus.

Dr. Hirsh is presently conducting research with grants from the Medical Research Council, the Canadian Heart and Stroke Foundation and the Trillium Award from the Ministry of Healh. A noted author, Dr. Hirsh has published 481 articles in reference journals, as well as written 189 book chapters, 14 books and 256 abstracts.

Second Mid-Winter Session to discuss controversies surrounding prostate cancer, hypertension

The Second Session at this year's WVSMA/WVACP's Mid-Winter Seminars and Scientific Conferences will be devoted to *"Controversies in Medicine,"* specifically focusing on prostrate cancer and hypertension.

This session will begin at 8:30 a.m. on Saturday, January 20 with a live demonstration of MDTV between Charleston and Morgantown which will be conducted by **Dr. Joseph Skaggs,** the medical consultant for CAMC in Charleston, and **Dr. James Brick,** a professor of medicine at WVU in Morgantown. MDTV will continue to broadcast programs throughout the day via a monitor in the Exhibit Hall. This demonstration will conclude at 4 p.m. with a lecture on *"Telemedicine"* by Drs. Skaggs and Brick for the Third Scientific Session. (*See details next page.*)

At 9 a.m., the *"Controversies in Medicine"* portion of the program will start with a lecture on *"Prostate Cancer: Evolving Concepts"* by **Ronald L. Hrebrinko, M.D.**, assistant professor of urologic surgery/urologic oncology at the University of Pittsburgh. After a break, this session will reconvene with the lecture *"Present Day Management of Hypertension"* by **William H. Carter, M.D.** and **Asif Rahman, M.D.** of Charleston.

Bios on Drs. Skaggs and Brick appear in the article on the next page, and brief CVs of Drs. Hrebrinko, Carter and Rahman begin below.

Speakers highlighted

Dr. Hrebinko received his M.D. degree from the University of Pittsburgh in 1986, where he also did postgraduate studies in general surgery and a four-year residency in urology.

Carter

While completing his residency in urology, Dr. Hrebinko studied for three months as a registrar in urology with the Royal College of Surgeons at Beaumont Hospital in Dublin, Ireland. When he finished his residency, Dr. Hrebinko did a fellowship in urologic oncology at the Roswell Park Cancer Institute in Buffalo, N.Y., from 1992-93.

In 1993, Dr. Hrebinko was named a clinical instructor at the University of Pittsburgh, and went into private practice in Pittsburgh. The following year, he was promoted to his current post as an assistant professor of urologic surgery, and also accepted his other present role as the director of male reproductive services at Planned Parenthood of Western Pennsylvania.

Dr. Carter is a native of Virginia who received his M.D. degree from the University of Virginia in 1963. He and completed his internship and residency at Bellevue Hospital and Columbia Medical Center in New York.

From 1965-67, Dr. Carter served in the Air Force, and then continued his postgraduate studies at Duke University with a fellowship in cardiology. He taught at Duke as a clinical instructor in cardiology until 1970, when he moved to Charleston and went into private practice.

A fellow and past governor of the American College of Cardiology and a past representative of the Council of Clinical Cardiology, Dr. Carter is now a clinical professor of medicine at WVU School of Medicine.

Dr. Rahman was born in Geneva, Switzerland, and received his medical degree from J. N. Medical College in Aligarh, India, in 1975. He came to the U.S. the following year to become a staff physician at Moose Lake State Hospital in Moose Lake, Minn.

In 1977, Dr. Rahman moved to New York to do an internship in pediatrics and a residency in medicine at the Jewish Hospital and Medical Center of Brooklyn. After his residency, he continued his postgraduate work at North Shore University Hospital in Manhasset, N.Y., from 1981-83, where he was a fellow in nephrology and hypertension.

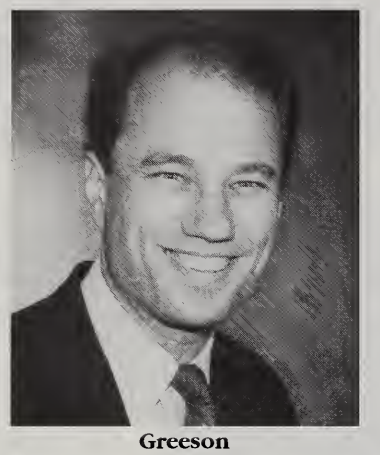
Dr. Rahman's career then brought him to Charleston, where he went into practice with the Charleston Renal Group, Inc., and joined the staff of the Charleston Area Medical Center. In 1985, he opened his current practice for nephrology and hypertension.

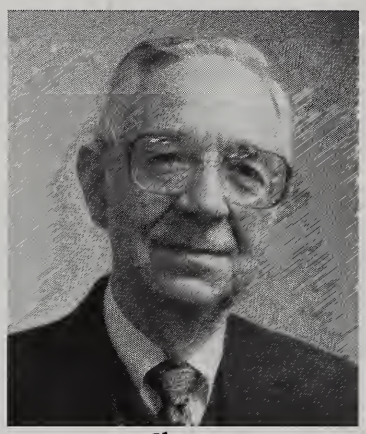
A diplomate of the American Board of Internal Medicine, Dr. Rahman is a clinical associate professor of medicine at the WVU School of Medicine, Charleston Division.

At Mid-Winter

Economic credentialing, telemedicine among topics for session on "New Age of Medicine"

Powers


Greeson


Skaggs

Brick

"A New Age of Medicine" is the title of the Third Scientific Session at this year's WVSMA/WVACP Mid-Winter Seminars and Scientific Conferences.

This diverse session is scheduled for Saturday, January 20 at 2 p.m., starting with a lecture on *"Early Dection/Disease Prevention,"* by **Roxann Powers, M.D.**, professor of medicine for the WVU School of Medicine in Morgantown. After Dr. Powers' talk, **Thomas W. Greeson, J.D.**, general counsel of the American College of Radiology, will address the subject of *"Economic Credentialing."*

Following a break, this session will reconvene with *"Clinical Pathways,"* a lecture by **Valerie A. Hopkins, R.N., M.S.N., C.P.H.Q.,** of Cabell Huntington Hospital. This session will conclude with a lecture on *"Telemedicine"* via MDTV by **Joseph Skaggs, M.D.**, the medical staff consultant for the Charleston Area Medical Center, and **James E. Brick, M.D.**, a professor of medicine for the WVU in Morgantown. Their lecture is part of a special live demonstration of MDTV, which is being conducted in the Exhibit Hall that day. *(See article on previous page.)*

MD TV™

Speakers highlighted

Dr. Powers received her medical degree from the West Virginia University School of Medicine in Morgantown in 1976, and then completed an internship and first year of residency in the Department of Medicine at WVU. She completed her residency at the Bowman Gray School of Medicine in Winston, Salem, N.C.

In 1979, Dr. Powers was named an instructor in the Department of Medicine at WVU, and the following year she was promoted to assistant professor of medicine. In 1985, Dr. Powers was elevated to the associate professor, and in 1992 she was named to her current role as professor of medicine. In addition, Dr. Powers serves as section chief of the General Internal Medicine Section and as medical director for Employee Health for WVU Hospital

A fellow of the American College of Physicians, Dr. Powers is also a member of the Society of General Internal Medicine and the American Geriatrics Society.

Mr. Greeson is an honors graduate of Chicago-Kent College of Law, who also holds a B.B.A. and an M.B.A. from the University of Georgia. He has been the general counsel of the American College of Radiology since 1983.

During his career, Mr. Greeson has written numerous articles on the legal issues facing physicians and drafted legislation to protect physicians' interests in the changing health care environment. He is frequently invited to speak to various physician and legal groups on issues ranging from hospital medical staff issues to professional liability.

Prior to joining the ACR, Mr. Greeson was a senior legislative analyst with the Alliance of American Insurers in Chicago. He holds professional designations as a Chartered Life Underwriter. He is licensed to practice law in Illinois, Virginia and Washington.

Ms. Hopkins received her A.A. degree in nursing from Morris Harvey College in 1973, and her B.S.N. and M.S.N. degrees from WVU. She is also certified through the National Association of Healthcare Quality.

For the past 14 years, Ms. Hopkins has been involved with utilization review and quality assurance. She currently is the director of Quality and Resource Management for Cabell Huntington Hospital in Huntington, where she oversees the utilization management, quality assessment/ improvement, medical affairs and infection control programs.

Ms. Hopkins also serves as a consultant to hospitals in West Virginia, Ohio and Kentucky who are preparing for JCAHO surveys or implementing a QA/I (Performance Improvement). In addition, she assists physicians in preparing their responses to the West Virginia Medical Institute about inquires concerning utilization or quality issues.

Dr. Skaggs is a graduate of WVU who received his M.D degree at the University of Louisville in 1946. He completed his internship at the Broadlawns Polk County Hospital and then joined the U. S. Army.

Dr. Skaggs served at Gorgas Hospital in the Panama Canal Zone from 1948-49 and earned the rank of captain. Following his military service, he returned to Iowa where he practiced for two years in Des Moines and then completed a residency in internal medicine and allergy at the University of Iowa in Iowa City.

After his residency, Dr. Skaggs completed a fellowship in allergy at Roosevelt Hospital in New York. In 1955, he moved to Charleston to practice, and for the last 13 years he has been employed by the Charleston Area Medical Center, first as vice president for Medical Affairs and now as the medical staff consultant.

In addition to his role as CAMC's medical staff consultant, Dr. Skaggs is a clinical professor of medicine at the Robert C. Byrd Health Sciences Center, Charleston Division.

Dr. Brick received his M.D. degree from WVU in 1977, and then completed an internship and residency in medicine at WVU Hospital. From 1980-81, he continued his postgraduate studies at WVU Hospital with a fellowship in rheumatology, and then taught at WVU as an assistant professor for a year. From 1982-84, he left WVU to do a two-year fellowship in immunology and rheumatology at the University of Missouri in Columbia.

In 1984, Dr. Brick became an assistant professor of medicine in the Section of Rheumatology at WVU, and in 1989 he was named an associate professor. Dr. Brick was promoted to his current faculty post as a professor of medicine with tenure in 1994, and since he is currently chairman of the Board of Directors of the WVU Medical Corporation.

A noted author and researcher, Dr. Brick has written nearly 70 articles, book chapters and abstracts for scientific publications. He currently serves on the WVSMA's CME Committee, as well as on WVU's CME Committee and WVU's CME Subcomittee for Mountaineer Doctor Television (MDTV).

Urologists to meet in Morgantown

The WVU - WV Urological Society's Annual Update has been scheduled for March 15-16 in Morgantown.

The topic for the meeting will be *"Urinary Stones and Infections."*

For details phone Kathy Keener at (304) 293-2706.

AMA, Medical Assurance conducting seminars prior to Mid-Winter Meeting

In conjunction with the start of the WVSMA/WVACP's 1996 Mid-Winter Seminars and Scientific Conferences, two preconference seminars are planned for Thursday, January 18 at the Charleston House - Holiday Inn, the site for all Mid-Winter events.

The first seminar will be held from 8:30 a.m. - 11:30 a.m., and is entitled *"Making Sense of the Evolving Healthcare Environment."* It is being presented by AMA Financing and Practice Services Inc., a subsidiary of the AMA, and is designed to examine the evolving healthcare environment from the perspective of physicians and their office staffs. Participants will be provided with a overview of managed care and the acronyms associated with newer delivery systems.

To register for this seminar, contact Tim Allman at the WVSMA office, (304) 925-0342.

The second preconference event is a Loss Control Seminar, which will be presented by Medical Assurance of West Virginia, Inc.. This program will begin with a luncheon at noon which will be provided by Medical Assurance, and then the seminar will be conducted from 1 p.m. - 4 p.m.

This seminar's objectives are:

* To discuss the evolution of medical-legal liability issues, as well as the development of strategies to address these issues.

* To outline and examine the Medical Assurance claims philosophy and management of lawsuits, including defense orientation/going to trial, progress and stages of a medical malpractice lawsuit, expert witnesses, and deny and defend posture in non-meritorious suits.

*To participate in a case study presentation of an actual medical malpractice case, discussing the facts of the case, defense issues and strategies, and risk management issues of the case.

Physicians who are insured by Medical Assurance and attend this seminar will receive a 5% premium discount for two policy years. This discount is also available to physicians who are not currently insured by Medical Assurance if they become Medical Assurance policyholders within one year of attending a seminar.

To register for the seminar, phone Mary Ellen Keen at 346-8228 or 1-800-331-6298.

Ten loss control seminars set for 1996

In addition to the Physician Loss Prevention Seminar planned for Thursday, January 18 prior to the WVSMA/WVACP's Mid-Winter Seminars and Scientific Conferences *(see above article)*, Medical Assurance of West Virginia, Inc., has scheduled the following 10 Physician Loss Prevention Seminars for 1996:

Wednesday, May 22	**6 p.m.**	**Stratford Springs, Wheeling**
Thursday, May 23	**11 a.m.**	**Holiday Inn, Clarksburg**
Thursday, May 23	**6 p.m.**	**Eurosuites, Morgantown**
Friday, May 24	**6 p.m.**	**Holiday Inn, Martinsburg**
Thursday, June 20	**11 a.m.**	**Logan Country Club, Logan**
Thursday, June 20	**6 p.m.**	**Marriott, Charleston**
Friday, June 21	**11 a.m.**	**Radisson, Huntington**
Saturday, June 22	**8 a.m.**	**Holiday Inn, Bluefield**
Thursday, July 11	**6 p.m.**	**Beckley Hotel, Beckley**
Friday, July 12	**6 p.m.**	**Blennerhassett, Parkersburg**

Physicians who are insured by Medical Assurance and attend one of these seminars will receive a 5% premium discount for two policy years.

To register, phone Mary Ellen Keen at 346-8228 or 1-800-331-6298.

The West Virginia State Medical Association's

1996 Mid-Winter Seminars and Scientific Conferences

January 19-21, 1996
Charleston House - Holiday Inn

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P.O. Box 4106
Charleston, WV 25364

Conference Cost:	WVSMA member	$125	_____
	non-member	$175	_____
	nurse	$75	_____
Seminar	**(Thursday, Jan. 18)** Making Sense of the Evolving Healthcare Environment	$125	_____
Lunch & Learn	**(Saturday, Jan. 20)**		
	physician	$50	_____
	all others	$35	_____
	TOTAL		_____

The West Virginia State Medical Association is offering **two** seminars you don't want to miss!

Making Sense of the Evolving Healthcare Environment

Thursday, January 18, 1996
Charleston House - Holiday Inn
8:30 a.m. to 11:30 a.m.

This program is designed for nurses, medical office staff and interested physicians and examines the evolving healthcare environment from their perspective. It will provide participants with an overview of managed care and the acronyms associated with newer delivery systems. Market factors that drive health care also will be discussed with a special emphasis given to quality and cost containment.

The cost of the seminar is $125 and is presented by AMA Financing & Practice Services, Inc., a subsidiary of the American Medical Association. This program precedes the annual Mid-Winter Clinical Conference. For more information, contact Tim Allman at (304) 925-0342. To register, please fill out the registration form on the opposite page and fax to Misty at (304) 925-0345.

The Anatomy of Domestic Violence

Lunch & Learn - Saturday, January 20, 1996
Charleston House - Holiday Inn

noon to 1:30 p.m.

Whether you are a physician, nurse or work as a member of the medical office staff, you each have a strategic role in identifying possible victims of domestic violence. Learn the telltale signs of domestic abuse and what to do.

The keynote speaker and facilitator, Devika Malhotra, is a sociology professor at West Virginia University - Parkersburg. A panel of distinguished guests also will participate in this open discussion. The cost is $50 for physicians and $35 for office managers. To register, please fill out the registration form on the facing page and fax to Misty at (304) 925-0345.

Continuing Medical Education

Listed on this page are some of the upcoming CME programs for physicians which will be held in the state and region. Unless otherwise noted, these events are presented at the location under which they appear.

If you would like to have the CME programs offered by your organization printed in the *Journal*, contact Nancy Hill, managing editor, at 925-0342.

Charleston Area Medical Center - Charleston

December 7
(Teleconference) "Hypertension: Old Disease - New Approach," Shawn A. Chillag, M.D., and Mary Lou Lewis, M.D.

Robert C. Byrd Health Sciences Center of WVU - Morgantown

December 2
"Low Tension Glaucoma: Evaluation and Treatment" (sponsored by WVU Dept. of Ophthalmology), Euro-Suites Hotel, Morgantown

December 6
"Resolving Conflict in Patient Care" (sponsored by the WVU Center for Health Ethics and Law and the WV Network of Ethics Committees), Morgantown

December 8
"Has the Pendulum Swung Too Far" Starting and Stopping Dialysis in the 1990s: Medical and Legal Considerations" (sponsored by the WVU Center for Health Ethics and Law and the Mid-Atlantic Renal Coalition), Crystal City Marriott, Arlington, Va.

December 9
"Current Methods in Rating Impairments and Monitoring Treatments" (sponsored by the WVU Institute of Occupational and Environmental Medicine and the Bureau of Employment Programs Workers' Comp. Div.), WVU School of Osteopathic Medicine, Lewisburg

West Virginia State Medical Association - Charleston

January 19-21
"WVSMA's 1996 Mid-Winter Seminars and Scientific Conferences," Charleston House Holiday Inn, Charleston

Outreach Programs

Fairmont ★ Fairmont Clinic, Dec. 20, 1 p.m., "Basic Geriatric Principles," William Shockcor, M.D.

Grafton ★ Grafton City Hospital, Dec. 7, 1:30 p.m., "Uterine, Ovarian and Cervical Cancer," Gerald Pretorius, M.D.

Montgomery ☐ Montgomery General Hospital, Dec. 6, 12:30 p.m., "Esophageal Cancer," Jay Requarth, M.D.

New Martinsville ★ Wetzel County Hospital, Dec. 15, 7 p.m., "Immunology Made Ridiculously Simple," Paris T. Mansmann, M.D.

Parkersburg ☐ Camden-Clark Hospital, Dec. 12, noon, TBA, Michael Schiano, M.D.

★ Camden-Clark Memorial Hospital, Jan. 10, 7:30 a.m., "Post Herpetic Neuralgia," Roberto Valenzuela, M.D.

Philippi ★ Broaddus Hospital, Dec. 14, 1 p.m., "Update in Congestive Heart Failure," David A. Law, M.D.

Waynesburg, Pa. ★ Green County Memorial Hospital, Jan. 9, 7 p.m., "The Physician as an Expert Witness," Thomas Adamski, M.D.

White Sulphur Springs ★ The Greenbrier Clinic, Nov. 27, 4 p.m., "High Resolution CT of the Chest," Janis Hurst, M.D.

★ The Greenbrier Clinic, Dec. 11, 4 p.m., "Bone Marrow Transplant," Joseph Lynch, M.D.

★ *Robert C. Byrd HSC of WVU*

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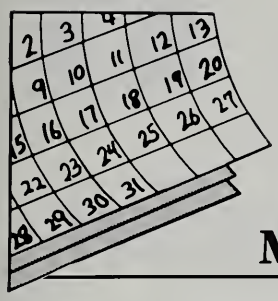


Medical Meetings

December

7-8–Preventive Services (sponsored by the Joint Commission on Accreditation of Healthcare Organizations), St. Louis, Mo.

7-8–Fall Developers' Conference (sponsored by the Medical Records Institute), Boston

8-10–The 13th Annual Advances in Heart Disease: An International Perspective (sponsored by the American College of Cardiology), San Francisco

11-13–Interpretation and Treatment of Cardiac Arrhythmias (sponsored by the American College of Cardiology), Philadelphia

11-15–1st International Conference of Therapies for Viral Hepatitis, Kauai, Hawaii

13-15–The Seventh Annual Atlanta Medical Management Conference (sponsored by the Medical Management Institute), Atlanta

14–The 42nd Annual National Health Forum -- Quality Managed Care: Meeting the Needs of High-Risk Patients and Populations (sponsored by the National Health Council), Washington, D.C.

14-16–Association of Reproductive Health Professionals, Washington, D.C.

January

10-13–American Association for Hand Surgery, Palm Springs, Calif.

11-14–National Association of EMS Physicians, Naples, Fla.

15-19–The 27th Annual Cardiovascular Conference (sponsored by the American College of Cardiology),

17-21–21st Annual Meeting of the Alliance for CME (sponsored by George Washington University), Orlando, Fla.

18-21–1996 MRI Orthopedic & Sports Injuries Review (sponsored by the MRI Education Foundation, Inc.), Cincinnati

19-21–The WVSMA's 1996 Mid-Winter Seminars and Scientific Conferences, Charleston

19-21–21st Gastrointestinal Surgery Symposium (sponsored by the American Society of Abdominal Surgeons), Tampa

February

1-4–6th International Prostate Cancer Update, Beaver Creek, Colo.

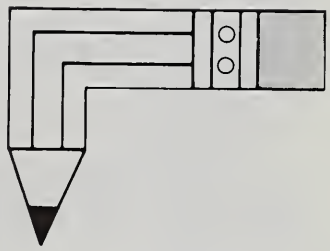
4-7–Southeastern Surgical Congress, Tampa, Fla.

6-10–Winter Symposium on Latest Advances in Facial Plastic Surgery (sponsored by the American Academy of Facial Plastic and Reconstructive Surgery), Snowmass, Colo.

7-10–American Group Practice Association, Miami Beach

For More Information...
Contact the Journal at (304) 925-0342

Poetry Corner



The Man in Blue

In Chaucer's day I'm told
The verse was lusty and bold
A limerick or two
and a fine howdy-do
and ale that never was cold

So there was a man in our town
Who wore a blue velvet gown
Sat in an old rocking chair
in the courthouse square
and rocked till the sun went down

He kept on his lap
and old tabby cat
and hummed a tune no one knew
And he was still there
In the sweet morning air
As the sun steamed away at the dew

But there's no moral here
Just a rhyme for your ear
A nod, a yawn, and a wink
Nothing to ponder
Nothing to wonder
Nothing to make you think.

P. Van Swearingen, M.D.

"THE SAME PEOPLE WHO TOLD ME THE STORK BROUGHT ME, ARE MAKING ME STAND HERE FOR LYING."

This page of material is submitted and paid for by the Bureau for Public Health.

Rural health awards presented

The Third Annual Governor's Rural Health Awards were presented at the West Virginia Rural Health Conference in Barboursville from October 26-28. This year's recipients were Joseph Golden, M.D., M.P.H., of Raleigh County for Outstanding Rural Health Practitioner; Cabin Creek Community Health Council's Encephalitis Project for Outstanding Rural Health Community Project; West Virginia School of Osteopathic Medicine's Domestic Violence Program for Outstanding Rural Health Program; and James E. LeVos, M.D., M.P.H., F.A.A.F.P., of Ritchie County for Outstanding Rural Health Achievement.

Dr. Golden started his Gulf Family Practice clinic in Sophia in 1984, based on holistic, family-centered medical care. A former VISTA volunteer, Dr. Golden provides quality health care at the clinic, and also makes visits to 30 homebound patients on a regular basis. He is a leader in the battle against domestic violence as a board member of the Women's Resource Center, and serves as a clinical assistant professor of family practice.

In response to an epidemic of enteroviral encephalitis in eastern Kanawha County, the Cabin Creek Community Health Council began a multifaceted project to reduce the incidence of the disease. The project included an education program to tell children how to avoid the disease, labor and materials donated by businesses and community members to cover an open ditch in a local school yard, and efforts to work with the local Public Service District to develop long-term plans for proper sewage in the area to reduce further outbreaks. Since the severe outbreak in 1993, only one case of the disease has been reported in the area covered.

Two years ago, the West Virginia School of Osteopathic Medicine fostered a collaborative effort with the Family Refuge Center and the West Virginia School of Osteopathic Medicine Clinic, Inc., to address domestic violence issues in Greenbrier County. The goals of the partnership are to develop an education program for physicians and clinic staff to increase the recognition of domestic violence as a leading health risk for women and children and to improve the provision of clinical and social services provided to patients at the clinics involved.

Dr. LeVos is one of only two full-time physicians in Ritchie and Doddridge counties. He rotates between clinics in three communities, providing patient care for three long-term care facilities, and serving as medical examiner for Ritchie County, medical director for Ritchie County emergency squads, and physician-supervisor of the Ritchie County Middle/High School Wellness Center. He is described as a physician who provides emotional, intellectual, physical, social, and spiritual support to all of his clients.

For more information on the Governor's Rural Health Awards, call the Bureau's Office of Community and Rural Health at (304) 558-3210.

Report looks at physicians in WV

According to a new report entitled *"Physicians in West Virginia,"* 3,039 doctors of medicine (MDs) and 313 doctors of osteopathy (DOs) were actively practicing medicine in West Virginia as of June 30, 1994. Of those physicians, approximately 46% of the MDs and nearly 73% of the DOs specialized in one of the primary health care services of family practice, general practice, gynecology, obstetrics and gynecology, internal medicine and pediatrics.

The report, issued by the West Virginia Bureau for Public Health's Office of Epidemiology and Health Promotion, used license renewal information from the West Virginia Board of Medicine and the West Virginia Board of Osteopathy to compile statistics on MDs and DOs on state, district and county levels. It looks at the number of doctors licensed, their primary setting of employment, their primary practice site, and their primary specialty. For MDs, information was also available on medical schools, birthdates and gender.

The primary setting of employment most frequently cited in the report for MDs and DOs was private practice, with more than 44% of MDs and about 29% of DOs practicing in office settings. One-fourth of MDs and nearly 23% of DOs reported that they worked primarily in a hospital setting.

The most frequently reported primary practice sites among MDs were Kanawha County (18%), Monongalia County (14%), and Cabell County (10%). Among DOs, the most frequent sites were Greenbrier County (12%) and Kanawha County (10%).

In other statistics provided in the report, the most frequently reported primary specialties among MDs were internal medicine (17%) and family practice (14%). Over half (58%) of the DOs listed general practice as their primary specialty, with emergency medicine as the next most frequently cited specialty at a distant 11%.

From the information available for MDs only, the report states that nearly 37% of MDs graduated from medical schools outside of the United States. The Philippines was the foreign country of graduation most often represented, followed by India. Together, these two countries accounted for almost one-fifth of all MDs actively practicing in the state. More than one-third of all active MDs were between the ages of 40 and 49, while over 10% were aged 65 or older. In addition, the statistics indicated that 15% of West Virginia's MDs are female.

"Physicians in West Virginia" is the first comprehensive look at doctors practicing in the state in nearly a decade. It was compiled as part of the uniform health professionals data systems established by the Legislature in 1991.

For more information or for a copy of the report, call the Bureau's Health Statistics Center at (304) 558-9100.

Mark Your Calendar!

The 1996 West Virginia State Medical Association
Annual Meeting is Coming Soon

August 21-24, 1996

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The theme for the 1996 Annual Meeting will focus on cardiology.

Scientific Topics include: *Interventional Cardiology: Promises Fulfilled?* Kenneth M. Kent MD
Office Evaluation of Children with Suspected Heart Disease, William A. Neal MD

Please be sure to make hotel reservations early by calling (800) 624-6070. For more information about other hotels in the area, contact the WVSMA at (304) 925-0342. For your convenience, you may register for the conference by calling the above number and using your Visa or MasterCard.

ROBERT C. BYRD HEALTH SCIENCES CENTER
OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

WVU opens PET center

Gupta

The WVU School of Medicine has opened the first Positron Emission Tomography (PET) center in the state.

This $10 million facility, located at the Health Sciences Center, enables physicians to view the functioning of organs and systems in the human body. It is expected to greatly advance the ability of physicians to diagnose cancer, neurological and heart diseases, and other serious illnesses.

The PET center at WVU is part of the Center for Advanced Imaging. Construction of the center, and purchase of the PET equipment was made possible through a federal grant to WVU arranged with the assistance of Senator Robert C. Byrd.

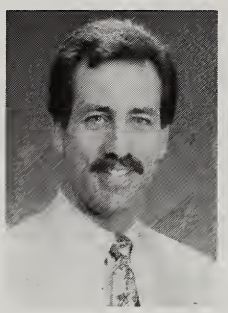
The completion of the center moves WVU into the forefront of medical imaging in the United States, says Dr. Naresh Gupta, director of the PET center. "Of the 60 PET centers in the country, this is one of the first to install General Electric's most advanced PET scanner. It offers the highest resolution available, and is capable of scanning the entire body."

WVU has applied to the West Virginia Health Care Cost Review Authority to make the PET center available for scans requested by physicians. Until approval is granted, the PET center will be operating for research studies only.

In a PET test, patients are injected with small quantities of short-lived radioactive tracer material. The tracer is carried in the bloodstream to the organ the doctor wants to study. The scanner detects positrons emitted by the tracer, and records chemical activity and other data about the organ. Then a computer analyzes the data, producing a color picture of how the organ is working.

The isotopes required for PET studies are produced, on-site, in a cyclotron. WVU's PET center is the first in the U.S. to house a new model of cyclotron, also produced by GE, that allows simultaneous production of two different radiopharmaceuticals.

New treatment offered for cancer patients


Korb

WVU physicians are killing tumors from the inside out with a new technique which drastically reduces patients' exposure time to radiation, according to Dr. Leroy Korb, chief of the section of radiation oncology.

High-dose rate brachytherapy can be used to treat lung, esophageal, prostate and gynecologic cancers.

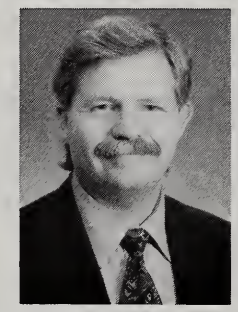
"We insert a small plastic catheter into the tumor and then the new system uses a computer-controlled 'robot' to place radioactive material into the catheter," says Dr. Korb. "By doing this, we limit the amount of healthy tissue exposed to radiation. We also can better control the amount of radiation a tumor receives. This leads to better tumor control with fewer side effects."

Patients receive high-dose rate radiation on an outpatient basis in about five to seven 20-minute sessions. "The procedure is totally painless, and patients often don't know the treatment has been given," says Dr. Korb.

Before the new high-dose rate brachytherapy, these patients would receive low-dose rate radiation and be required to stay in the hospital for three or four days, according to Dr. Korb. "Now, they're in and out in minutes."

Not all cancer patients are candidates for high-dose rate radiation therapy. Physicians who would like to know more about this new technique should call the WVU's Section of Radiation Oncology at (304) 293-4106.

Linberg named chair of ophthalmology


Linberg

Dr. John V. Linberg has been named chair of WVU's Department of Ophthalmology and director of University Eye Center.

A member of the faculty and director of the oculoplastic, orbital and lacrimal surgery service at University Eye Center since 1983, Dr. Linberg is also a member of the executive medical board and chairs the physicians health committee at WVU Hospitals.

Dr. Linberg earned his M.D. degree at New York University School of Medicine and completed a residency in ophthalmology at St. Luke's Hospital, Columbia University in New York. He also had specialized training in oculoplastic and orbital surgery at the University of Iowa.

"Dr. Linberg is internationally recognized for his expertise in anatomy and surgery of the lacrimal system - the tear glands and ducts," says Dr. Robert M. D'Alessandri, vice president for health sciences and dean of medicine at WVU. "He is also widely respected for his research in oculoplastic and orbital disease."

Dr. Linberg succeeds Dr. George Weinstein who chaired the department from 1980 until August of this year.

WVU initiates SIDS Awareness Campaign

The state's mortality rate for Sudden Infant Death Syndrome (SIDS) has not changed in the last 10 years, so WVU's Department of Community Medicine has launched a campaign to alert the public on the dangers of putting newborns to sleep on their stomachs.

"The public needs to know that a baby who is put to sleep on the back or side - - as opposed to the stomach - - is less likely to die from SIDS, says R. John Pearson, M.B., M.P.H., chair of the Department of Community Medicine.

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Marshall University School of Medicine

MU
MARSHALL UNIVERSITY

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

MU creates special diabetes network with Benedum grant

Boosted by a $300,000 grant from the Claude Worthington Benedum Foundation, Marshall has launched a multifront attack on diabetes by creating the Appalachian Diabetes Health Promotion Network. This project, which is co-directed by Dr. Richard Crespo of the School of Medicine and Dr. Lynne Welch of the School of Nursing, is developing model education and outreach programs in Cabell, Wayne, Lincoln and Mason counties.

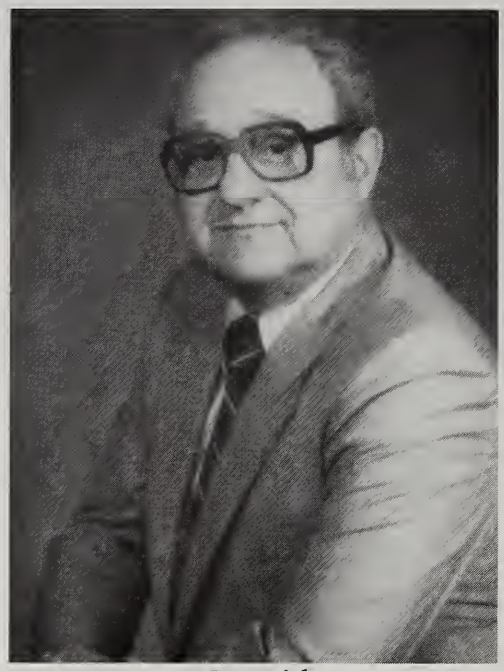
The key to reducing diabetes and it complications, Drs. Crespo and Welch believe, is to combine the efforts of patients, providers, educators and health officials. Their goal is to make rural residents partners in diabetes prevention and management, and to provide better training and support for health professionals. Once developed, this system will be able to serve as a model for other Appalchian regions.

In each of the participating counties, community-based coalitions are being developed to draw on the leadership of people with diabetes. Through the Benedum project, MU is helping the groups develop prevention programs and train lay diabetes health workers.

"The lay health workers are pivotal," Dr. Crespo said. "When people need to change their basic at-home behavior, as you need to with diabetes, peers often can help them more effectively than doctors and nurses can."

When the project ends in 1998, each of the target counties will have at least one coalition sponsoring diabetes health promotion programs, under the leadership of lay diabetes health workers. Each county will also have at least one certified diabetes educator. In addition, modules are being created about diabetes health care for students in nursing, medicine, dietetics, social work and exercise physiciology.

Room dedicated in honor of Dr. Lotspeich



Lotspeich

As part of Marshall's Medical Alumni Homecoming activities, a reading/conference room was dedicated in honor of the late Dr. Frederick J. Lotspeich. Kathleen Lotspeich, his widow, cut the ribbon to open the room, which is located in Marshall Coon Medical Education Building at the Huntington VA Medical Center.

The room will provide a classroom for advanced graduate students and discussion sessions for med students.

Dr. Lotspeich was the first chairman of MU's Department of Biochemistry, holding that position from 1977 until his retirement in 1991. He was a dominant figure in medical education in West Virginia, having previously taught for 21 years at the WVU School of Medicine. He is believed to have taught more West Virginia physicians than any other faculty member.

"The Lotspeich Reading Room enables future generations both the opportunity to appreciate the lengthy, dedicated commitment of Dr. Lotspeich and also to enhance their academic progress in a scholarly, stimulating atmosphere," said Dean Dr. Charles H. McKown Jr.

Grover co-authors article in *Science*

Dr. Lawrence M. Grover, an assistant professor of physiology at Marshall, has co-authored an article entitled *"The Mechanism of Biphasic GABA Responses,"* which was published in the August 18 edition of *SCIENCE.*

Dr. Grover was invited to comment on a new theory that may explain the puzzling dual role of a key chemical in the brain: a neurotransmitter known by the acronym GABA.

GABA has mystified scientists for years, Dr. Grover said. It usually functions to inhibit electrical impulses, however, at times it totally reverses its role and stimulates electrical activity instead. This second role may, he and his colleagues suggest, contribute to the brain's storage of memories by allowing calcium to enter nerve cells. The new theory, offered by researchers at the University of Colorado, expands on work previously published by Dr. Grover's group.

"The new version of the hypothesis put forth by Kevin Staley and his colleagues seems to be a significant step forward," Dr. Grover said. "It helps explain why some of our previous results were inconclusive, but as Nevin Lambert and I point out in our article, the most critical experiment which will either prove or disprove the new theory has not yet been performed."

Veitia appointed to development post

Marie C. Veitia, Ph.D., an associate professor of medical psychology, has been named director of educational development for the MU School of Medicine.

In this role, Dr. Veitia will develop a school-wide system for evaluating students and instructors, as well as a system to monitor students in clinical settings. She will also serve as a counselor to students, implement a research program in medical education, assist in special programs, and continue teaching as an associate professor.

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WVSMA-MSS Annual Meeting

January 20, 1996
Charleston House - Holiday Inn
Charleston, WV

8 a.m. - 8:30 a.m.	**Registration** - Cobb Room
8:30 a.m. - 9 a.m.	**Welcome** - WVSMA President James D. Helsley, MD, and WVSMA Executive Director George Rider
9 a.m. - 10 a.m.	**Special Session** - Jim Woody, AMA-MSS Governing Council Chairman
10 a.m. - 11 a.m.	**Special Session** - *"Identifying the Victims of Domestic Violence"* Speaker to be announced
11 a.m. - 11:30 a.m.	**Break** - Exhibit Visitation
11:30 a.m. - 12:30 p.m.	**Luncheon** - Provided by WVSMA-MSS
1 p.m. - 4 p.m.	**Business Meeting**

*Presidential Address
*Component Society Reports
*Election nominations
*Committee Reports

WVSMA-MSS Annual Meeting Registration Form

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Address: _____ City: _____ State: _____ Zip: _____

Will you attend luncheon? _____ Yes _____ No

Please fax or mail to Donna Webb at WVSMA-MSS, P.O. Box 4106, Charleston, WV 25364
Phone: (800) 257-4747 or 925-0342 Fax: (304) 925-0342

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Summersville, WV

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Greenbrier, WV

Daniel E. Speilman, MD
Greenbrier, WV

Jeffery L. Leaberry, MD
Barboursville, WV

Bartlett A. Stone, MD
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Glen Dean McKnight, MD
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Albert K. Leung, MD
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Peter J. Nicholson, MD
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Jerry Fogle, MD
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Anna F. Fakadej, MD
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Max West, MD
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Charleston, WV

Kathleen W. Hahn, MD
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Thomas Mathew, MD
Bluefield, WV

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WVU School of Medicine Charleston

Tucker G. Jennings
Helen R. Kirk

WVU School of Medicine Morgantown

Ronald J. Pellegrino
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Cecilio G. Delgra Jr.
Benjamin M. Bernstein
Amanda L. Moran
Michael E. Renforth
Matthew J. Metz
Wendy S. Neel
Ward J. Paine
Brent E. Watson
David B. Watson
Larry V. Starcher II
Andrew M. Foy
Dana M. Lese
Jennifer L. Jones
Michele D. Fleak
Carla M. Price
Laura Davisson
Brian K. Griffith
Michele Maouad
Brian James Caveney
Parham Farid
Susan R. Benson
Jeffrey R. Wienke
Peter G. Pantelidis
Joseph M. Baisden
Mark A. Hackney
Samuel C. Rossi
Brian A. Plants
Christopher P. Simon
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Jeremy A. Roberts
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Karen A. Glogowski
Scott F. Young
Samir Patel
Melissa D. Kitzmiller
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Bethany S. Hiener
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John E. Cornell
Patrick M. Dom
Jerry R. Stafford
Frank E. Fumich
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If your county is not represented, contact your component society president.

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Component Society News

FAYETTE COUNTY

At their October meeting, Michelle Ellison of the WVSMA, addressed members about the Mini Internship Program which is designed to give community leaders and individuals an inside look at the daily lives of health care professionals.

Michelle reported that several component societies have already conducted mini internships and been pleased with the results. The members then discussed the possibility of having a program and stated they would contact the WVSMA in the future if plans are confirmed.

Dr. Joseph Skaggs, the medical staff consultant for CAMC, was another special guest at the meeting. He introduced Dr. David Anderson of CAMC, who presented a CME lecture entitled *"The Classification and Use of Pap Smears in 1995 and Beyond."*

In other business, a Nominating Committee was appointed and asked to bring recommendations to the November meeting for the election of officers for 1996.

At the November meeting, Dr. Fred Kerns of CAMC gave an update on the diagnosis and management of streptococcal infections.

Following a question and answer session, Dr. A. Amjad, president of the Fayette County Medical Society, called for a report from the Nominating Committee. Since very few members were present at this meeting, it was decided to postpone the election of officers until the December meeting.

Obituaries

Robert Russell Dennison Sr., M.D.

Robert Russell Dennison Sr., M.D., 76, of Proctorville, Ohio, died at home on September 29.

Dr. Dennison was a graduate of Marshall University and the Medical College of Virginia. He interned at C & O Hospital in Huntington and then served as a captain in the Army during World War II.

Dr. Dennison served the Huntington community for more than 50 years. He was also involved with the West Virginia Department of Rehabilitation for many years, and served as the head of the C & O Clinic. Dr. Dennison was on staff at St. Mary's Hospital for over 50 years, as well as on the staffs of Cabell Huntington Hospital, Presbyterian Manor and Mariner Health Care.

A WVSMA member since 1947, Dr. Dennison was also a member of Medical College of Virginia Alumni Association, the SMA, the AMA, the American Society of Internal Medicine, and Theta Kappa PSI Medical Fraternity. In addition, he also held memberships in the American Legion Post 16, B.P.O. Elks Lodge 313, the Smithsonian Associates, Guyan Boating Association, and Who's Who of American Business Leaders.

Dr. Dennison received many honors during his lifetime included being named an Honorary West Virginian, Distinguished West Virginian and named to the Honorable Order of Kentucky Colonels.

Dr. Dennison was preceded in death by his parents, Jess Theodore and Mary Stepp Dennison; and his first wife, Edith Forsythe Dennison. He is survived by his wife, Elizabeth Dennison; six children, Carol Lewis of Columbia, S.C., Melissa Dennison of Charleston, Michael Dennison of Spokane, Wash., Robin Adkins of Huntington, Dr. Robert Russell Dennison Jr. of Winchester, Ky., and Deborah Prino of Lavalette; and 12 grandchildren, Robert Russell Dennison Lewis, Mary Elizabeth Lewis, Emily Michele Lewis, Russell Preston Dennison, Madeline Elizabeth Dennison, John Russell Dennison, Heather Melissa Dennison, Michele Elizabeth Adkins, Jennifer Page Adkins, Timothy Adkins, Kathryn Celeste Prino and Edith Ellen Prino; one great-grandchild, Chase Adkins; and one brother and one sister, Charles W. Dennison, M.D., of Huntington, and Mary Lou Farmer of Proctorville.

David H. Gatherum, M.D.

Dr. David Hoge Gatherum, 77, of Bluefield, Va., died June 6 in a Princeton hospital.

Born in Athens, W.Va., Dr. Gatherum was a son of the late Robert Storer and Nancy Dangerfield Gatherum. He was a graduate of Concord College and the University of Virginia Medical College in Charlottesville. He served his residency at the University of Wisconsin in Madison.

After his residency, Dr. Gatherum served as chief of anesthesia for Milwaukee County General Hospital and taught at Marquette University. In 1962, he came to West Virginia to work at Bluefield Sanitarium, and he was the first board certified anesthesiologist in the state. He organized the Bluefield Sanitarium School of Nursing for Anesthesia, and also formed Bluefield Anesthesia Associates when Bluefield Sanitarium closed. In addition, Dr. Gatherum helped create Bluefield Regional Medical Center which opened in 1976.

Dr. Gatherum served in the U.S Naval Reserves during World War II. In addition to being a member of the WVSMA, Dr. Gatherum was a member of the AMA, and the Mercer County Medical Society. He was a past president of the Bluefield Rotary Club and a past president of the South Bluefield Kiwanis Club.

Dr. Gatherum was preceded in death by his wife, Mary Margaret Roth Gatherum, and two brothers. He is survived by his sons, Stanley David Gatherum of Rogers, Ark., and Dean Robert Gatherum of Princeton.

Contributions may be made to Concord College Scholarship Fund, Box 83, Athens, W.Va., 24712.

John Freeman Otto, M.D.

Dr. John Freeman Otto of Huntington died October 6 at Cabell Huntington Hospital.

A native of New York, Dr. Otto was the only son of the late John and Florence Otto. He entered Harvard University at age 15, earning his B.A. degree in three years and graduating in 1943. He then received his M.D. degree from the University of Cincinnati School of Medicine, graduating with honors in 1948 and being awarded the Peter T. Kilgore prize for outstanding scholarship and character.

Dr. Otto served his internship and residency training at Boston City Hospital, followed by a research fellowship in endocrinology at Tufts University. He then served in the Army in Korea from 1952-54 in the Medical Corps as a battalion surgeon with the 45th Division, earning the Combat Medical Badge and the Bronze Star.

After returning from Korea, Dr. Otto completed a research fellowship in cardiology at Thorndike Memorial Laboratory at Harvard from 1954-55. He then came to Huntington to serve as the medical director and chief of medicine for the Chesapeake and Ohio Railway Hospital. In 1971, he entered private practice as a partner of Huntington Internal Medicine Group, where he practiced until his retirement in 1992. During his career, Dr. Otto was also a clinical assistant professor of medicine at Marshall University.

A past president of the Cabell County Medical Society, the West Virginia Society of Internal Medicine and the Board of Directors of Region II Health Planning Association. He was the founder and served as the president of Valley Health Systems from 1976-78, and continued as a member of the Board of Directors until his death. He also served as vice-chairman for the Region II Health Advisory Committee of West Virginia Health Systems Agency and as chairman of the West Virginia State Health Coordinating Council.

Dr. Otto had been a WVSMA member since 1958, and was also a member of the AMA, the American College of Physicians, and the American Society of Internal Medicine.

Dr. Otto is survived by his wife, Virginia Holt Otto; four children, David Dwight Otto of Hungtington, Deborah O. Weaver of New Richmond, Ohio, Marilyn M. Otto, M.D., and her husband, James C. Goetz, M.D., of Huntington, and Karen S. Otto Miller and her husband, Paul E. of Barboursville; four grandchildren, Brenda Weaver, Audrey Weaver, Emily Goetz and Evan Goetz.

The family has requested that donations be made in memory of John F. Otto, M.D. to the American Diabetes Association, 1221-A Ohio Ave., Dunbar, WV 25064 or the West Virginia Heart Associaton, 211 35th St. E., Charleston, WV 25305.

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Contributions for WESPAC/AMPAC are not deductible as charitable contributions for federal income tax purposes. A portion of your WESPAC contribution is sent to AMPAC thus enrolling you as an AMPAC member as well.

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